NATIONAL BOARD FOR CERTIFIED COUNSELORS® AND AFFILIATES

Medicare Mental Health Workforce Coalition

Making Informed Decisions Before Submitting Claims to Medicare

July 25, 2024

Sponsored by the Medicare Mental Health Workforce Coalition

Meeting Details

1. **Closed Captioning** is enabled and attendees can turn CC on or off as they desire.
2. **Interpreter Phone Number: 305-224-1968** **Webinar ID: 894 1725 7027** **Passcode: 964662**
3. **Session Evaluation / Take Our Evaluation Survey** (CE credit for live attendance only)
4. Webinar will be posted on NBCC website a few days following the webinar.
5. **Q&A:** Please add your questions in the Q&A box at any time during the meeting.

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- American Association for Marriage and Family Therapy
- American Counseling Association
- American Mental Health Counselors Association
- Association for Behavioral Health and Wellness
- California Association of Marriage and Family Therapists
- Centerstone
- Center for Medicare Advocacy
- Michael J. Fox Foundation for Parkinson's Research
- National Association for Rural Mental Health
- National Association of Community Health Centers
- National Association of County Behavioral Health and Developmental Disability Directors
- National Board for Certified Counselors
- National Council for Mental Wellbeing
- National Council on Aging
- Network of Jewish Human Service Agencies
- The Jewish Federations of North America

Learning Objectives

After this webinar, attendees will be able to:

Identify resources for screening Medicare clients for eligibility.

Differentiate accurate procedure and diagnosis codes for services.

Verify coding and unit reporting accuracy.

Describe the use of modifiers to report unique service situations.

Apply tips and reminders for submitting claims.

Stephanie Portzline

Stephanie Portzline is the Manager of Provider Engagement for Novitas Solutions, Inc., and First Coast Service Options, the Part A and B Medicare Administrative Contractors (MAC) for Jurisdictions L, H, and N. She has served in various capacities in the Medicare program for more than 10 years, managing provider enrollment and contact center operations, critical and congressional provider and beneficiary inquiries, and the provider outreach and education program. Stephanie received a master's degree in educational leadership and policy from Shippensburg University.

Amy Ascher

Amy Ascher, CPC, CEMC, is a Part B Provider Outreach and Education Specialist for Novitas Solutions, Inc., with over 40 years of Medicare experience specializing in billing and claim submission, modifiers, telehealth/telemedicine, evaluation and management (E/M), and preventive and behavioral health services. Amy is also a Certified Professional Coder (CPC) and Certified Evaluation and Management Coder (CEMC) by the American Academy of Professional Coders. Her goal as a tenured educator is to instill the knowledge and provide access to the tools for providers to bill Medicare services correctly the first time.

Making Informed Decisions Before Submitting Claims to Medicare

July 25, 2024
Time 12:00 p.m. ET
Time 11:00 p.m. CT
Time 10:00 a.m. MT

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- This presentation is a general summary that explains certain aspects of the Medicare program but is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

Acronym List

Acronym	Definition
AOC	Add-on Codes
ASCA	Administrative Simplification Compliance Act
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedure Coding System
ICD-10-CM	ICD-10 Clinical Modification
LCA	Local Coverage Article
LCD	Local Coverage Determination
MAP	Medicare Advantage Plan
MBI	Medicare Beneficiary Identifier
MFT	Marriage Family Therapist

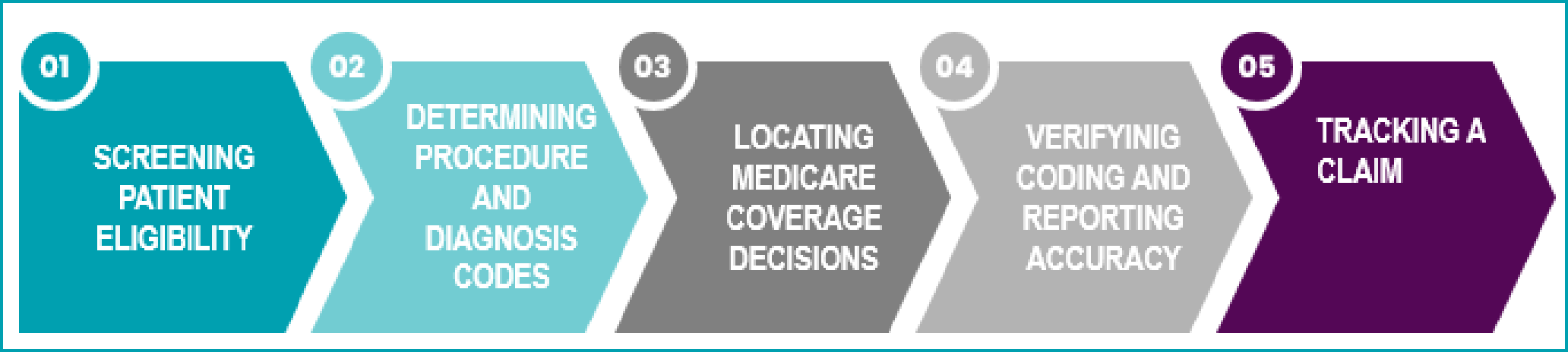
Acronym List 2

Acronym	Definition
MHC	Mental Health Counselor
MSP	Medicare Secondary Payer
MUEs	Medically Unlikely Edits
NCCI	National Correct Coding Edits
NCD	National Coverage Determinations
PTP	Procedure to Procedure

Today's Presentation

- **Agenda:**
  - Elements to Proper Claim Submission
  - Screening Patient Eligibility
  - Determining the Appropriate Procedure and Diagnosis Code
  - Locating a Medicare Coverage Policy
  - Verifying Coding and Reporting Accuracy
  - Tracking a Claim
  - Reviewing a Step-by-Step Scenario
  - Helpful Resources

Elements of Proper Claim Submission



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Key Elements

- **Verifying these critical elements of information will prevent improper payments, and reduce administrative rework with claim correction and/or resubmission:**
  - **Screening for patient eligibility:**
    - Identify current insurance:
      - Checking for Part A, Part B or Part C entitlement
      - Is Medicare primary or secondary
    - Patient screening is a vital step that is critical to every type of practice
    - Prevents billing errors and denials
  - **Determining the appropriate procedure and diagnosis code:**
    - The documentation determines the appropriate procedure and diagnosis code that should be submitted
    - It is important to verify the coverage of the procedure code/service and that it is rendered by a certified medical professional within their state scope of practice
  - **Locating a Medicare coverage policy:**
    - All services billed to Medicare must be medically necessary
    - Local Coverage Determinations (LCD)s or National Coverage Determination (NCDs)

Key Elements Continued

- **Verifying coding and reporting accuracy:**
  - CMS developed NCCI edits to control improper coding and inappropriate payments
  - It is important to review the edits to prevent claim denials, prior to submitting claims
  - Use modifiers to indicate a service or procedure performed has been altered by some specific circumstance, but not changed in its definition or code
  - Report referring and ordering physician as required
  - **Tracking a claim:**
  - Follow Administrative Simplification Compliance Act (ASCA) requirements
  - A claim must be filed with the appropriate Medicare contractor on a form/electronic equivalent in accordance with CMS instructions
  - Payment floor establishes a waiting period during which time the contractor may not pay, issue, mail, or otherwise finalize the initial determination on a clean claim
  - It is important to include the specific type of documentation requested and respond promptly when addressing an ADR request
  - Several options are available to check claim status:
    - MAC online provider portal
    - IVR
    - Remittance Advice (RA):
      - Paper or electronic

Screening Patient Eligibility

Patient Screening Overview

- **Background:**
  - All providers/practitioners should screen their Medicare patients to obtain correct health insurance information before submitting a claim to Medicare
- **Purpose:**
  - Prevents rejected and denied claims and ensures reimbursement from the correct insurer
  - Faster payments if sent to the correct payer the first time
- **Collecting information:**
  - Patient screening is a vital step that is critical to every type of practice
  - Front office staff plays a key role in the success of filing claims correctly and timely
  - Taking a few minutes with the patient or patient's responsible party to collect the correct insurance information at every visit, can prevent reimbursement delays
- **Three common patient screening-related billing errors include:**
  - Medicare Advantage (MA) plan denials
  - MSP denials
  - Beneficiary eligibility denials

Provider Responsibilities for Patient Screening

- **During patient registration it is important to:**
  - Copy the Medicare card and/or other insurance cards
  - Verify the patient's name and Medicare number on the Medicare card:
    - The name used on all documents should match the Medicare card exactly
  - Patient eligibility information can be obtained from the Medicare card
  - If the patient joins Medicare Advantage (MA) plan or terminates Part B coverage, the patient may still, continue to carry the Medicare card:
    - Don't only use the Medicare card as a guarantee of Medicare eligibility
- **The Social Security Administration (SSA) determines eligibility for Medicare:**
  - Issues regarding eligibility or card replacement are handled by SSA:
    - 1-800-772-1213 (TTY 1-800-325-0778)

The Medicare Card

- **The Medicare card contains an MBI number for Medicare transactions:**
  - Should be protected as Personally Identifiable Information
  - This card does not contain the Social Security Number, this helps protect the patient's identity
- **MBIs are randomly developed and assigned and use a combination of numbers 0 - 9 and uppercase letters, except for S, L, O, I, B and Z:**
  - We exclude these letters to avoid confusion when differentiating between these letters and numbers (e.g., between "0" and "O")

2024 Medicare Deductible, Coinsurance, and Premium Rates

Who

- Physicians, Hospitals, and Suppliers

When

- Effective: January 1, 2024
- Implementation January 3, 2024

What

- CY 2024 Medicare Deductible, Coinsurance, and Premium rates

- **Key Points:**
  - **2024 Part A – Hospital Insurance:**
    - Deductible: $1632.00
    - Coinsurance:
      - $408.00 a day for 61st-90th day
      - $816.00 a day for 91st-150th day (lifetime reserve days)
      - $204.00 a day for 21st-100th day (Skilled Nursing Facility coinsurance)
  - **2024 Part B –Medical Insurance:**
    - Deductible: $240.00 a year
    - Coinsurance: 20 percent
- **Reference:**
  - Medicare Learning Network (MLN) Article: MM13365 - Medicare Deductible, Coinsurance, & Premium Rates: CY 2024 Update

Registration Screening Questions to Determine Eligibility

- **Does the patient have Medicare Part A?**
  - **Part A hospital coverage includes:**
    - Inpatient hospital care
    - Inpatient care in a Skilled Nursing Facility (SNF) following a covered hospital stay
- **Does the patient have Medicare Part B?**
  - **Medicare Part B medical insurance coverage includes:**
    - Medically necessary services furnished by physicians and practitioners
    - Many preventive services
    - Home health care for individuals who do not have Part A
    - Ambulance services
    - Clinical laboratory and diagnostic services
    - Surgical supplies
    - Durable medical equipment, prosthetics, orthotics, and supplies
    - Hospital outpatient services

Registration Screening Questions to Determine Eligibility Continued

- **What Insurance is Primary or Secondary?**
  - Part A providers must complete the Medicare Secondary Payer Questionnaire (MSPQ):
    - Medicare Secondary Payer (MSP) Manual, Chapter 3 – MSP Provider, Physician, and Other Supplier Billing Requirements
  - Part B providers/suppliers are not required to complete the MSPQ, however you should have some type of screening in place to determine MSP information. A few suggested questions:
    - Marriage status
    - Employment status
    - Injuries
  - References:
    - MLN Booklet - Medicare Secondary Payer
    - Medicare Secondary Payer Manual, Pub. 100-05, Chapters 1-8

Registration Screening Questions to Determine Eligibility Continued

- **Is the patient in a skilled nursing home Part A stay?**
  - Skilled Nursing Facility (SNF) consolidated billing applies when a patient is in a SNF Part A stay and certain services will not be covered by Medicare Part B
- **Is the patient enrolled in Home Health?**
  - When a patient is enrolled in home health, certain services are provided by the home health agency and cannot be paid by Medicare Part A and B:
  - Reference:
    - Home Health Providers
    - Medicare Benefit Policy Manual, Pub. 100-02, Chapter 7 – Home Health Services

Additional Registration Screening Questions to Determine Eligibility

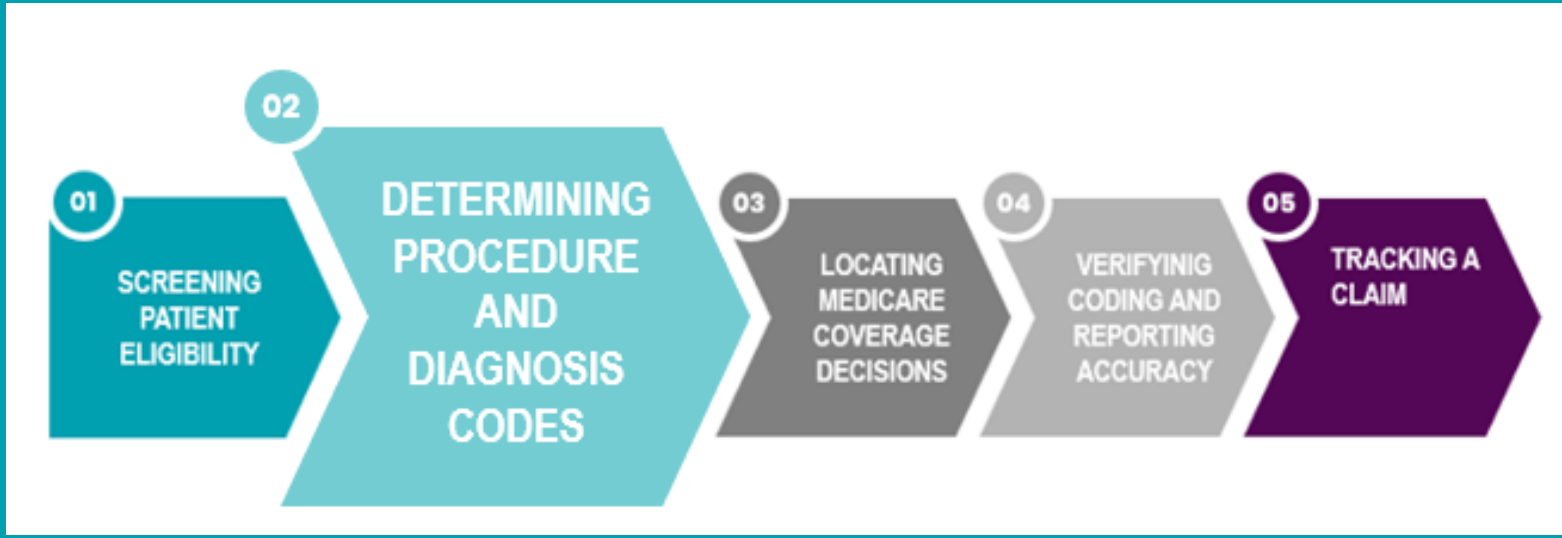
- **Is the patient enrolled in Hospice?**
  - Beneficiaries with Medicare Part A who have terminal illnesses and a life expectancy of six months or less have the option of electing hospice benefits in lieu of standard Medicare coverage for treatment and management of their terminal condition
  - For additional information, refer to the link listed below:
    - Medicare Benefit Policy Manual, Pub. 100-09, Chapter 9 - Coverage of Hospice Services Under Hospital Insurance

- **Is the patient enrolled in a Medicare Advantage Plan (MA)?**
  - Besides traditional Medicare, Congress created MA plans to let more private insurance companies offer coverage to people with Medicare, giving them more choices
  - MA plans (sometimes called Part C) and other Medicare plans are health plan options that provide both Part A and Part B benefits
  - MA Plan Directory

Options for Verifying Eligibility

- **Check patient eligibility through these online tools and services:**
  - Medicare Administrative Contractor (MAC) online provider portal
  - MAC Interactive Voice Response (IVR) system
  - Billing agencies, clearinghouses, or software vendors
  - Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS)
- **Reference:**
  - MLN Fact Sheet – Checking Medicare Eligibility

Determining the Appropriate Procedure and Diagnosis Code



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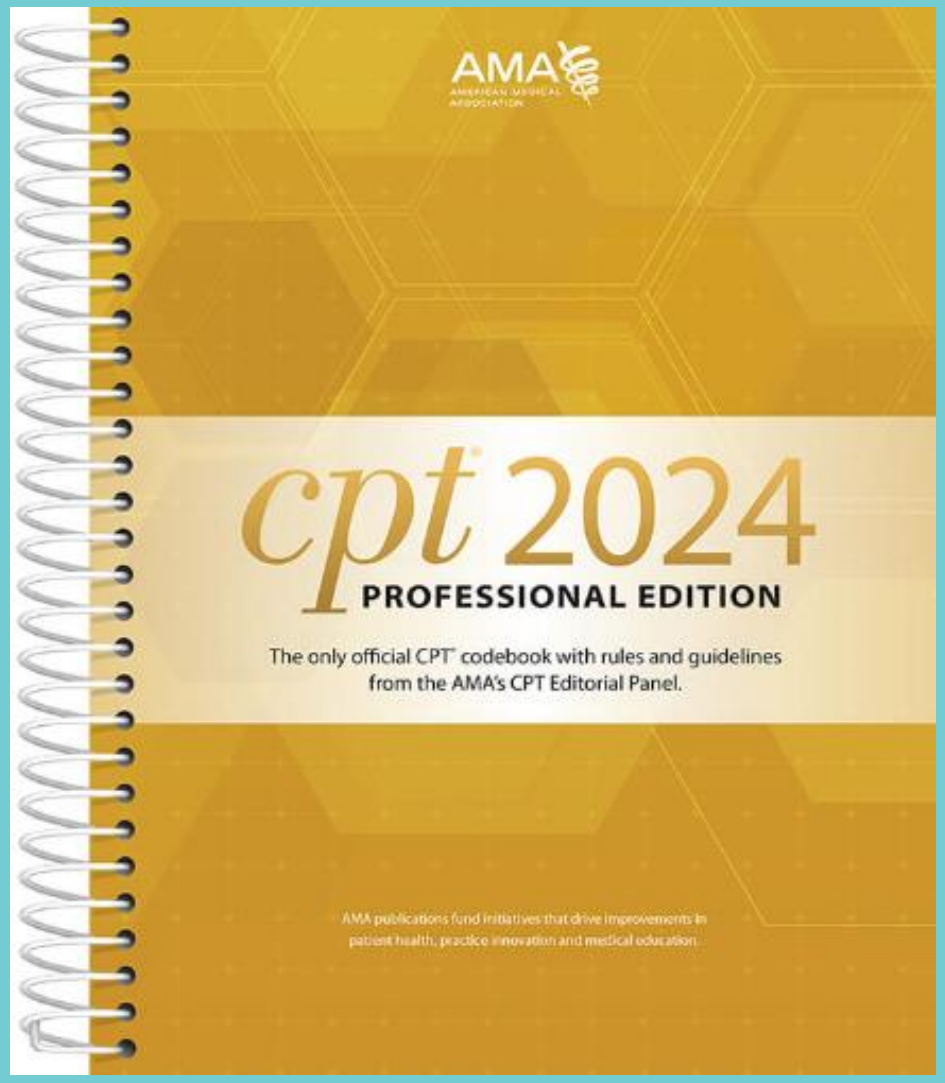
Coding Guidelines

- According to Medicare Contractor Beneficiary and Provider Communications Manual, Pub. 100-9, Chapter 6 - Provider Customer Service Program, Section 30.3.1 "Responding to Coding Questions", providers are responsible for determining the correct diagnostic and procedural coding for the services they furnish to Medicare beneficiaries
- Documentation must support the codes submitted on the claim
- The MACs are not allowed to assist with coding questions, e.g., which procedure code would I use to bill this service?
- These questions will need to be directed to the American Medical Association (AMA) http://www.ama-assn.org
- **References:**
  - AMA CPT Terminology
  - List of CPT/HCPCS Codes
  - HCPCS General Information
  - ICD-10 Resources

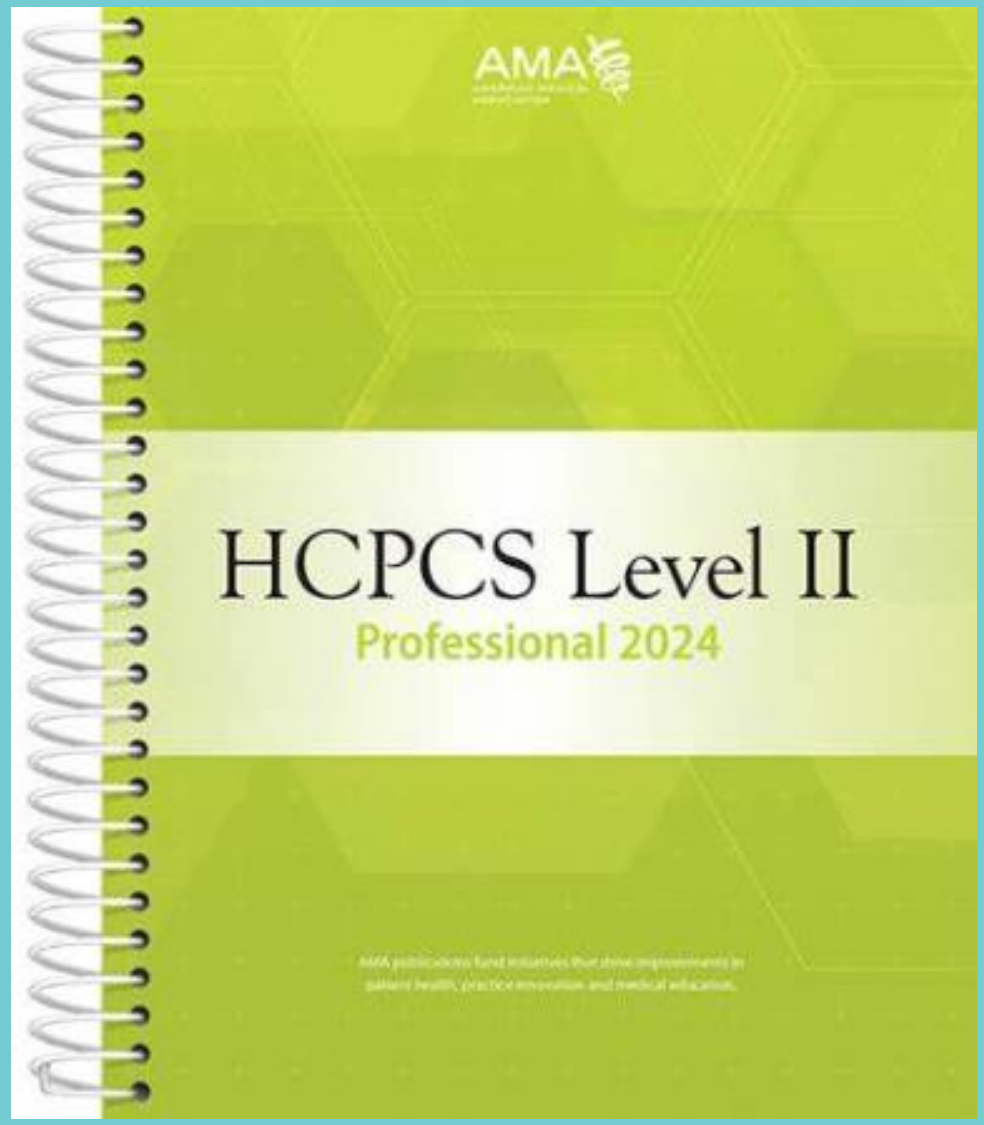
Current Procedural Terminology (CPT)

- **Definition:**
  - CPT codes are used to report services to Medicare and other insurers and may also be referred to as CPT category 1 code
- **Purpose:**
  - CPT code sets are published by the American Medical Association (AMA) annually:
    - Check the AMA CPT public website throughout the year to obtain necessary updates to the CPT code sets
    - CPT is a registered trademark of the AMA:
      - AMA CPT physician resource
  - To purchase a CPT book, visit the AMA website
- When submitting CPT codes, ensure the code used is valid for the date of service billed and covered under the Medicare program



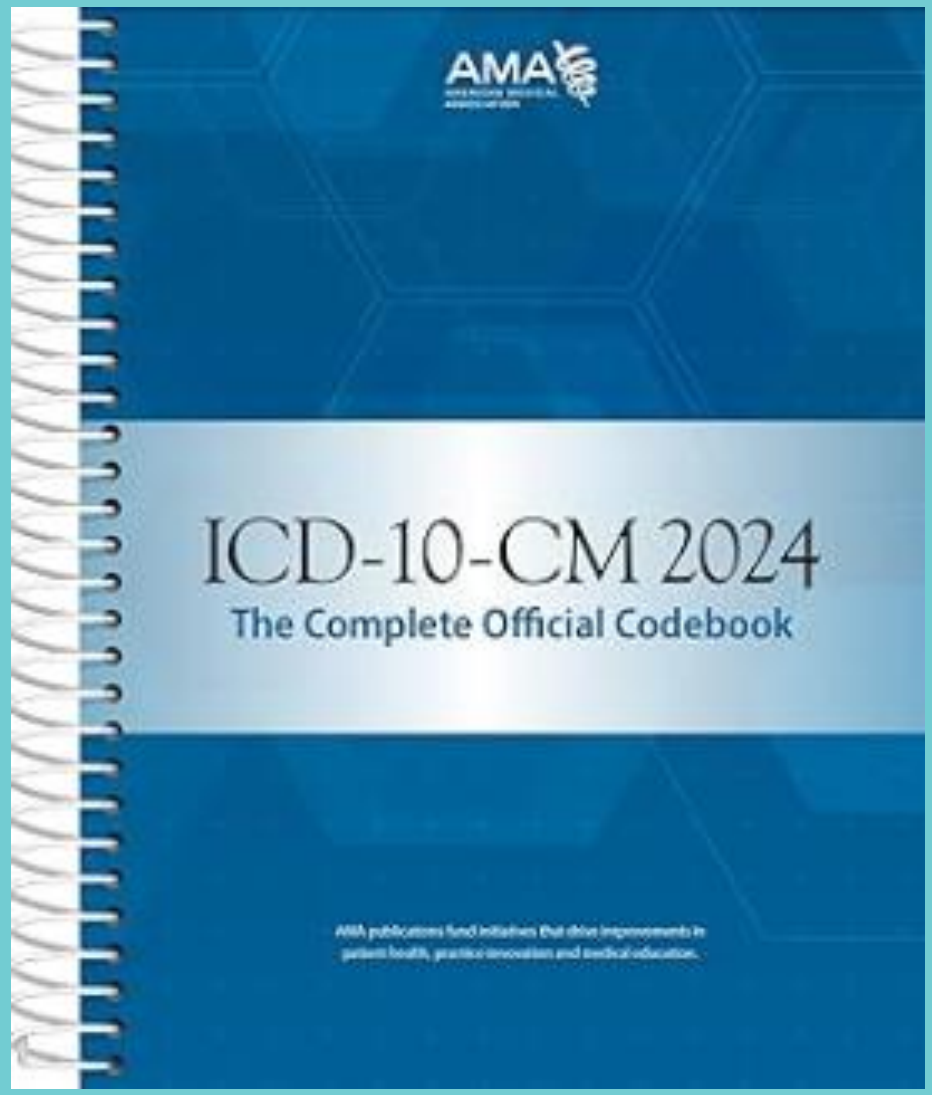
Healthcare Common Procedure Coding System (HCPCS)

- **Definition:**
  - CMS HCPCS is a collection of codes and descriptors that represent procedures, supplies, products and services
- **Purpose:**
  - HCPCS code sets are published by the AMA annually:
    - Check the AMA CPT public website throughout the year to obtain necessary updates to the HCPCs code sets
- HCPCS - General Information | CMS
- To purchase an HCPCS book, visit the AMA website.



ICD-10 Clinical Modification (ICD-10-CM)

- **Definition:**
  - ICD-10-CM is the standard transaction code set for diagnostic purposes
- **Purpose:**
  - To track health care statistics/disease burden, quality outcomes, mortality statistics and billing
- **Reference:**
  - ICD-10 Help & Resources



Modifiers

- **Definition:**
  - A modifier provides the means to report or indicate a service that has been performed has been altered by some specific circumstances from the procedure codes definition; however, the definition of the procedure code has not changed
- **Purpose:**
  - Modifiers enable health care professionals to effectively respond to payment policy requirements

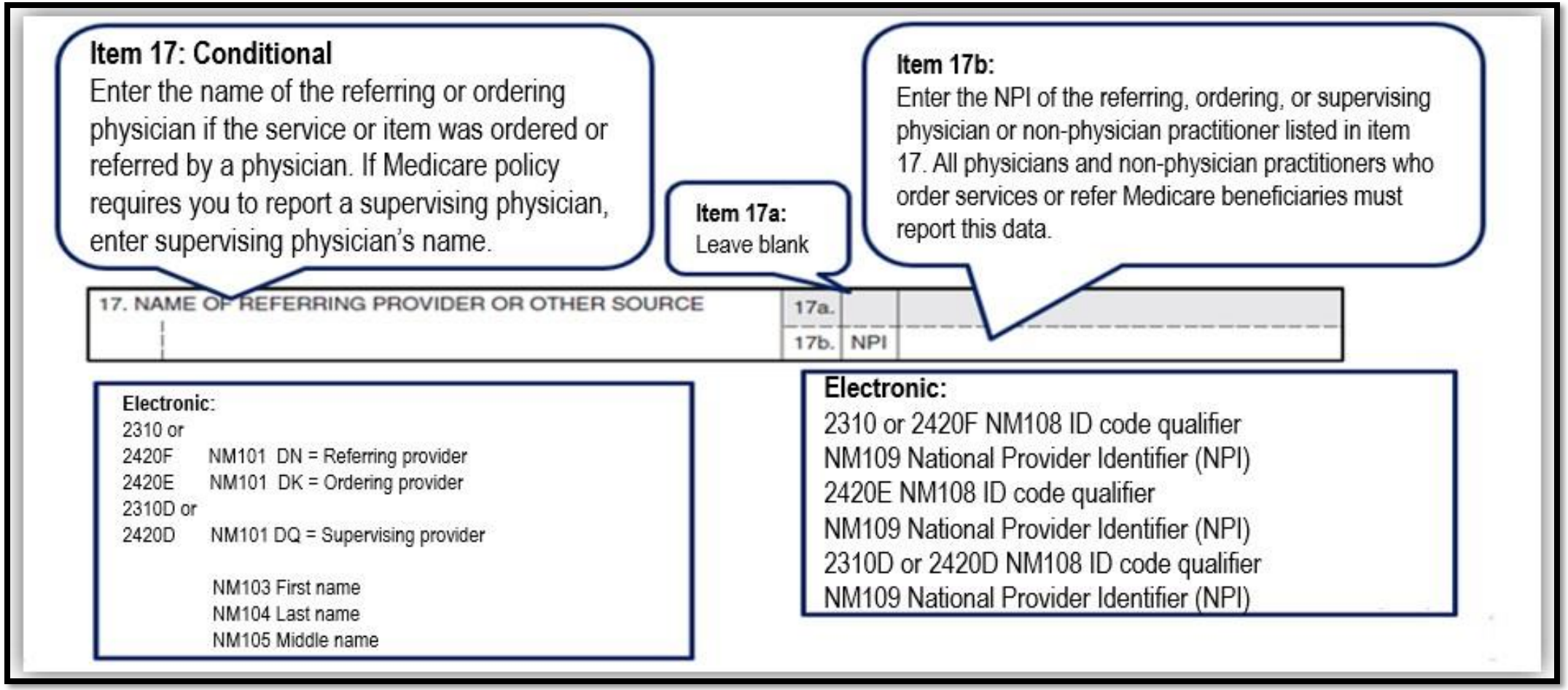
Reporting Modifiers on Medicare Claims

- Modifiers should be reported in Item 24D on the CMS-1500 claim form or the electronic equivalent
- **Payment modifiers include:**
  - 22, 26, 50, 51, 52, 53, 54, 55, 58, 62, 66, 78, 79, 80, 81, 82, AA, AD, AS, TC, QK, QW, and QY
- **Informational modifiers:**
  - Provides additional information but does not affect the reimbursement
  - Should be used in the second, third or fourth fields when payment modifiers are used:
    - When entering only informational modifiers the order does not matter

Referring and Ordering Physician Information

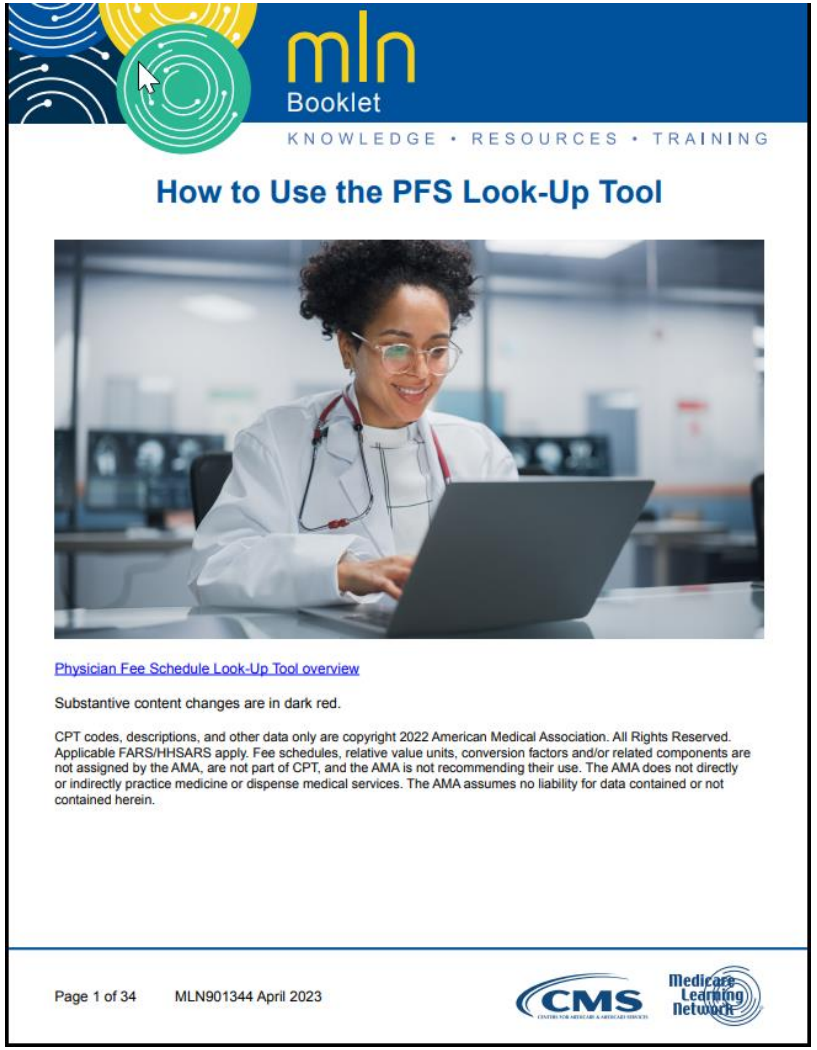
- **Definition:**
  - A referring physician is defined as a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program
  - An ordering physician is defined as a physician, or when appropriate, a non-physician practitioner who orders non-physician services for the patient
- **Purpose:**
  - To provide Medicare services that are a result of a physician's order or referral when the ordering physician is also the performing physician
  - **To provide incident to services:**
    - Services and supplies are integral to the patient's normal treatment course and the physician or other listed NPP personally furnished an initial service to which the auxiliary personnel's services are incidental
- **Reference:**
  - Medicare Claims Processing Manual, Pub. 100-04, Chapter 26 – Completing and Processing Form CMS-1500 Data Set, Section 10.4, "Items 14-33 Provider of Service or Supplier Information"

Items 17-17b: Referring/Order Physician Name and NPI



Physician's Fee Schedule (PFS) Look-Up Tool

- **The CMS PFS Look-Up Tool provides Medicare payment information including:**
  - Pricing
  - Single code search
  - Fee schedule detail
  - General status indicators
  - **Indicators:**
    - PC/TC components
    - Global surgery days
    - Bilateral surgery
    - Multiple procedures
    - Assistant at surgery
- **References:**
  - How to Use the PFS Look-Up Tool


mln Booklet
KNOWLEDGE • RESOURCES • TRAINING

How to Use the PFS Look-Up Tool

Physician Fee Schedule Look-Up Tool overview

Substantive content changes are in dark red.

CMS Medicare Learning Network

CMS Page – MFTs and MHCs

- MFTs and MHCs can bill Medicare independently for their services furnished for the diagnosis and treatment of mental illnesses
- CMS – Marriage and Family Therapists & Mental Health Counselors

Medicare & Mental Health Coverage

- **The CMS MLN Booklet on Medicare & Mental Health Coverage provides informative information:**
  - **Eligible Professionals:**
    - Individual provider-type required qualifications
    - Coverage, and
    - Payment criteria
  - Medicare-covered behavioral health services for MFTs and MHCs are notated with an **

UPDATE: The Centers for Medicare and Medicaid Services (CMS) has clarified and confirmed that mental health counselors (MHCs) and marriage and family therapists (MFTs) can bill for any services and codes (which the MHC or MFT is legally authorized to perform under State law) that are for the diagnosis and treatment of mental illnesses of Medicare beneficiaries that includes Health Behavioral Assessment and Intervention (HBAI) services.

Commonly Used CPT Codes for MFTs and MHCs

Table 12. Commonly Used Mental Health-Related CPT Codes (cont.)

Description	CPT Code
Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)	96131
Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	96132
Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)	96133
Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes	96136
Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)	96137
Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	96138
Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)	96139
Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	96146
Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)	96156**
Health behavior intervention, individual, face-to-face; initial 30 minutes	96158**
Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	96159**

**CPs, CSWs, MFTs, and MHCs can bill these codes.

Medicare & Mental Health Coverage MLN Booklet

Table 12. Commonly Used Mental Health-Related CPT Codes (cont.)

Description	CPT Code
Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes	96164**
Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	96165**
Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	96167**
Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	96168**
Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes	96170**
Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	96171**
Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); first 60 minutes	G0017
Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); each additional 30 minutes (List separately in addition to code for primary service)	G0018

**CPs, CSWs, MFTs, and MHCs can bill these codes.

UPDATE: The Centers for Medicare and Medicaid Services (CMS) has clarified and confirmed that mental health counselors (MHCs) and marriage and family therapists (MFTs) can bill for any services and codes (which the MHC or MFT is legally authorized to perform under State law) that are for the diagnosis and treatment of mental illnesses of Medicare beneficiaries that includes Health Behavioral Assessment and Intervention (HBAI) services.

Telehealth Services

- **Definition:**
  - **Visit with provider that uses telecommunication systems with audio and video capabilities between a provider and a patient:**
    - Use of interactive telecommunications system substitutes for in-person encounter
- **Purpose:**
  - **Use interactive audio and video telecommunications system permitting real-time communication:**
    - Distant site = practitioner's location
    - Originating site = patient's location
  - Use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services and behavioral health counseling and educational services
  - Current list of telehealth services
- Beginning with dates of service on and after January 1, 2024, MFTs and MHCs were added as distant site health professionals
- **Reference:**
  - MLN Fact Sheet: Telemedicine Services

List of Telehealth Services

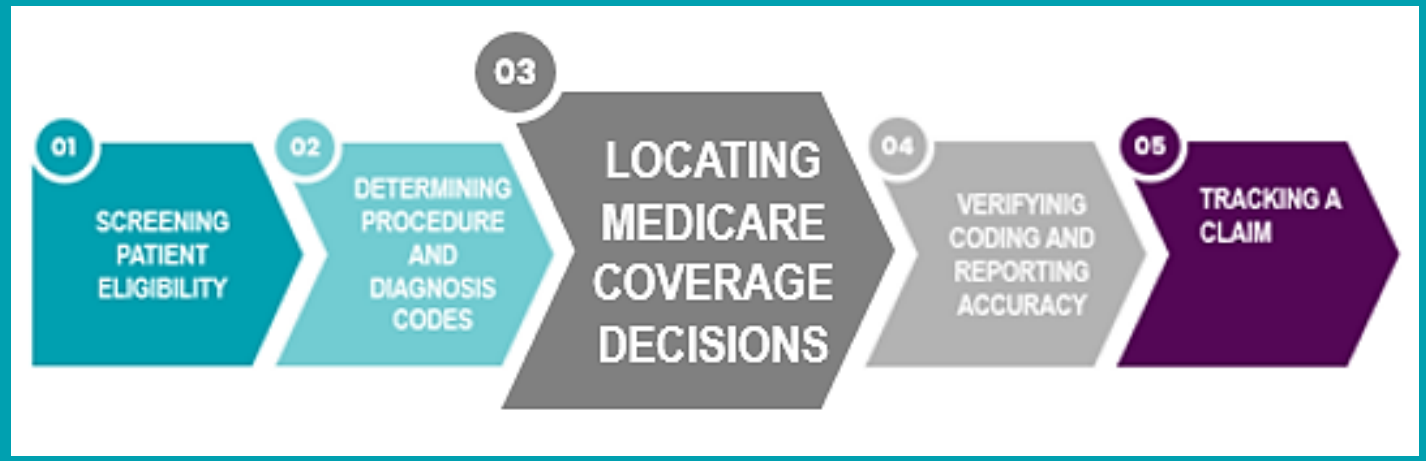
- CMS updated the List of Telehealth Services for CY 2024
- **New categories:**
  - Provisional (formally temporary)
  - Permanent
- Periodically check the telehealth listing for updates

LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2024 - updated November 13, 2023			
HCPCS	Short Descriptor	Can Audio-Only Interaction Meet the Requirements?	Category
96156	Hlth bhv assmt/reassessment	Yes	permanent
96158	Hlth bhv ivntj indiv 1st 30	Yes	permanent
96159	Hlth bhv ivntj indiv ea addl	Yes	permanent
96164	Hlth bhv ivntj grp 1st 30	Yes	permanent
96165	Hlth bhv ivntj grp ea addl	Yes	permanent
96167	Hlth bhv ivntj fam 1st 30	Yes	permanent
96168	Hlth bhv ivntj fam ea addl	Yes	permanent
96170	Hlth bhv ivntj fam wo pt 1st	No	provisional
96171	Hlth bhv ivntj fam w/o pt ea	No	provisional

Place of Service (POS) Codes and Modifier 95 – Telehealth

- **For dates of service on and after January 1, 2024, use:**
  - **POS 02 - Telehealth provided other than in patient's home:**
    - The location where health services and health related services are provided or received, through telecommunication technology.
    - Patient is not located in their home when receiving health services or health related services through telecommunication technology
  - **POS 10 - Telehealth provided in patient's home:**
    - The location where health services and health related services are provided or received through telecommunication technology
    - Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology
- Starting January 1, 2024, telehealth services provided to patients in their homes at the non-facility PFS rate
- Providers should continue to bill claims for telehealth services with the POS if the service had been done in person and modifier 95 through December 31, 2023
- **References:**
  - MLN Fact Sheet - Telehealth Service
  - Place of Service Codes

Locating a Medicare Coverage Policy



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Medicare Covered Services

- **Definition:**
  - Covered services are considered medically reasonable and necessary to diagnosis and treat a beneficiary's condition
  - **Medicare considers a service to be reasonable and necessary if it is determined the service is:**
    - Safe and effective
    - Not experimental or investigational
    - Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
    - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member
    - Furnished in a setting appropriate to the patient's medical needs and condition
    - Ordered and furnished by qualified personnel
    - One that meets, but does not exceed, the patient's medical need
    - At least as beneficial as an existing and available medically appropriate alternative
    - A service can be considered a non-covered service for many different reasons
- **References:**
  - Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15 – Covered Medical and Other Health Services
  - Section 1862(a) (1) (A) of the Social Security Act

Non-Covered Charges

- Not generally accepted in the medical community as safe and effective in the setting and for the condition for which it is used
- Not proven to be safe and effective based on peer review or scientific literature
- Experimental
- Not medically necessary in the particular case
- Furnished at a level, duration or frequency that is not medically appropriate
- Not furnished in accordance with accepted standards of medical practice
- Not furnished in a setting (such as inpatient care at a hospital or skilled nursing facility (SNF), outpatient care through a hospital or physician's office, or home care) appropriate to the patient's medical needs and condition
- **Not medically necessary:**
  - Services provided for convenience or cosmetic reasons

Local Coverage Determinations and Articles

- **Local Coverage Determination (LCD) Background:**
  - According to Section 1862(a)(1) of the Social Security Act, the CMS and its contractors may develop standards outlining what is “reasonable and necessary” for coverage under Medicare
- **LCD Purpose:**
  - Administrative and educational tools to assist providers in submitting correct claims for services covered by the Medicare program
- **Overview:**
  - CPT ICD-10 codes in LCDs have been placed in billing and coding articles linked to the LCD
  - Help to increase transparency, clarity, consistency, reduce provider burden and improve public relations while retaining ability to be responsive to local clinical and coverage policy concerns
- **Local Coverage Articles (LCA) Purpose:**
  - Convey billing and coding information/guidelines
  - Communicate any non-reasonable and necessary language
  - Companion to LCD or stand alone
  - Includes ICD-10 diagnosis codes, CPT and HCPCS codes
  - Communicate responses to comments submitted on proposed LCDs

National Coverage Determinations (NCDs)

- **Definition:**
  - Developed by the Centers for Medicare and Medicaid Services (CMS) to describe the circumstances for Medicare coverage nationwide for an item or service
- **Purpose:**
  - Generally, outlines the conditions an item or service is covered (or not covered) under §1862(a) (1) of the Social Security Act or other applicable provisions of the Act
  - **NCDs can be initiated by CMS if they find:**
    - Inconsistent local coverage polices exist
    - Service represents a significant medical advance, and no similar service is currently covered by Medicare
    - Service is the subject of substantial controversy
    - Potential for rapid diffusion or overuse exists
  - **NCDs can be found on the CMS website:**
    - Alphabetical index

Information Contained in National Coverage Determination (NCD) Review

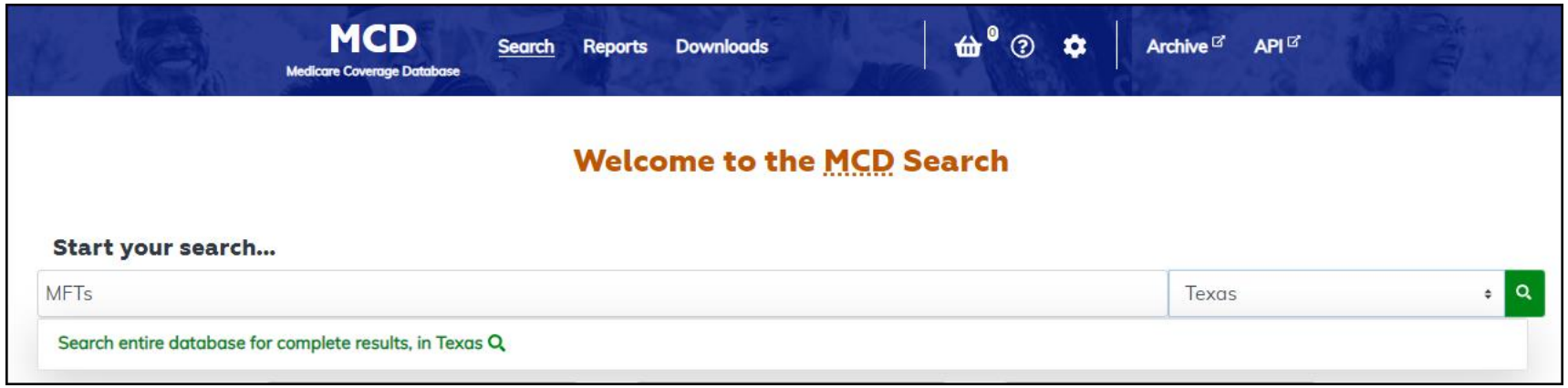
- **Information that may be contained in an NCD includes:**
  - **Description Information:**
    - Benefit Category
    - Item/Service Description
    - Indications and limitations of coverage and/or medical necessity
    - Claims Processing Instructions
  - National Coverage Analyses
  - Transmittal Information
  - Revision History
  - Additional Information
  - Procedure codes
  - Covered and/or non-covered diagnoses codes

Absence of an LCD or NCD

- **MACs and CMS do not develop an LCD or an NCD for every service or procedure that is covered:**
  - Absence of an LCD/NCD does not mean non-coverage
  - Providers should report services rendered appropriately:
    - Payment is made only for services that are medically reasonable and necessary and only when provided by certified medical professionals
- **A service or procedure can have other policies or guidelines besides an LCD/NCD (not an all-inclusive list):**
  - National Correct Cording Initiative (NCCI) edits
  - Medically Unlikely Edit (MUE)
  - Internet-Only Manual (IOM)
  - Medicare Learning Network (MLN) articles
  - Physician Fee Schedule

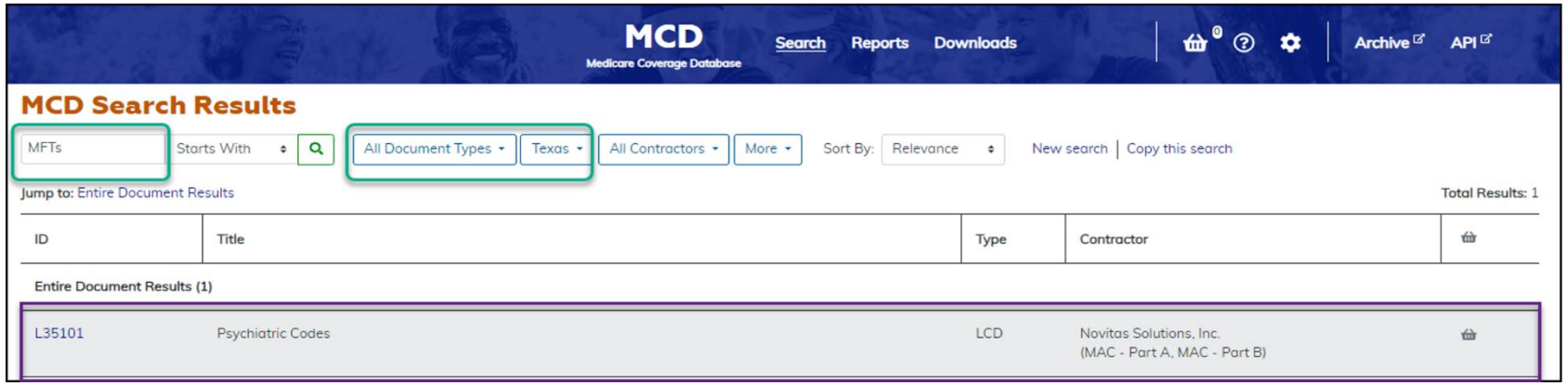
Medical Coverage Database Search by Contract

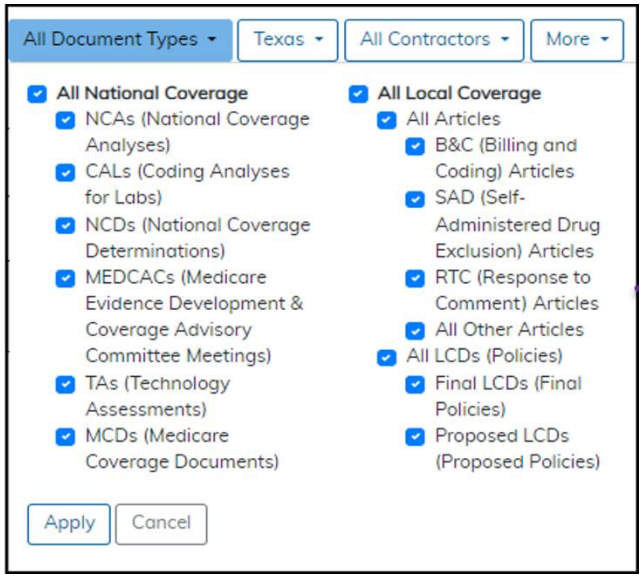
- Medicare Coverage Database Search:
  - Enter Keyword and select the MACs state
  - Select the search



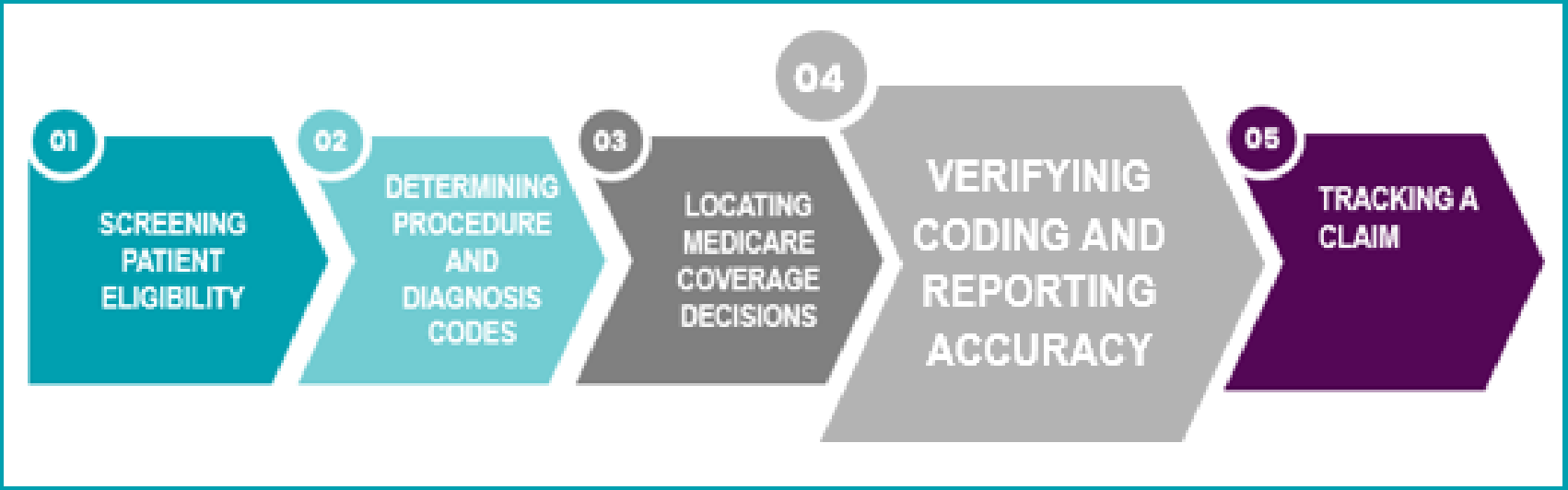
Medical Coverage Database Search Results

- **Results of the search:**
  - Page will show any NCDs, LCDs and LCAs for the MAC contract and topic selected
  - Under all document types for the MAC state will appear in the search:





Verifying Coding and Reporting Accuracy



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National Correct Coding Edits

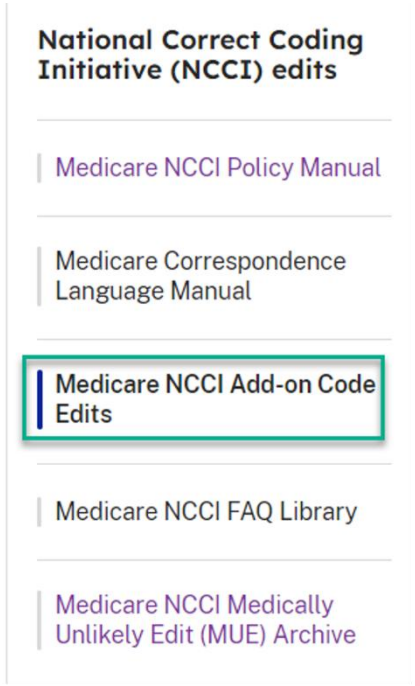
- **Definition:**
  - CMS developed NCCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payment
- **Purpose:**
  - Applies to coding policies defined in the AMA, CPT Manual, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice
  - **Includes the following:**
    - Procedure to Procedure (PTP) Edit Pairs
    - Add-On-Codes (AOC)
    - Medically Unlikely Edits (MUEs)
- **Resource:**
  - MLN Booklet - How to Use the Medicare National Correct Coding Initiative (NCCI) Tools

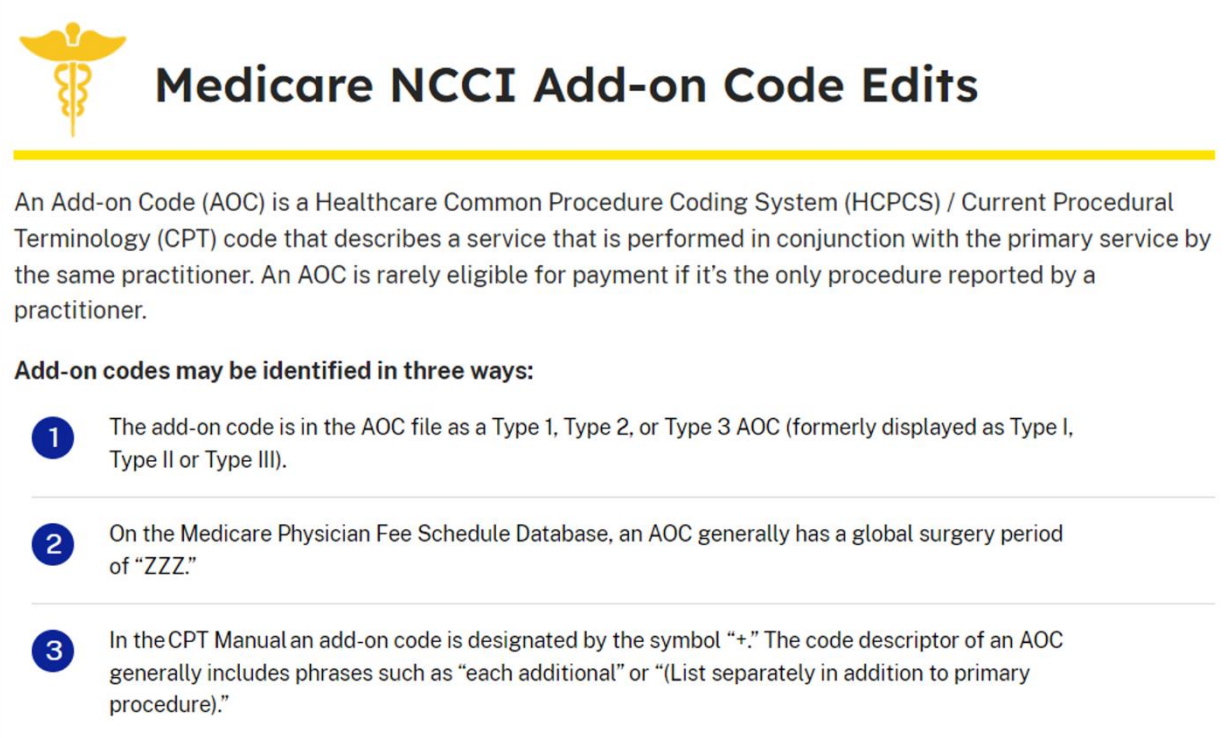
Definition and Purpose of AOCs

- **Definition:**
  - A HCPCS or CPT code describing a service always performed in conjunction with another primary service
- **Purpose:**
  - AOCs are services eligible for payment if they are reported with the primary procedure
- Report the primary and the AOC on the same claim
- **Codes are divided into three types of payment policy groups:**
  - Type 1 AOCs identified in the CPT, HCPCS and other CMS policies defining primary procedures
  - Type 2 AOCs are developed by contractors
  - Type 3 AOCs with the primary procedure codes specifically identifiable and defined in The CPT Professional Edition coding manual

How to Locate AOCs

- [Medicare NCCI Add-on Code Edits]





Medicare NCCI Add-on Code Edits

An Add-on Code (AOC) is a Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) code that describes a service that is performed in conjunction with the primary service by the same practitioner. An AOC is rarely eligible for payment if it's the only procedure reported by a practitioner.

Add-on codes may be identified in three ways:

1. The add-on code is in the AOC file as a Type 1, Type 2, or Type 3 AOC (formerly displayed as Type I, Type II or Type III).
2. On the Medicare Physician Fee Schedule Database, an AOC generally has a global surgery period of "ZZZ."
3. In the CPT Manual an add-on code is designated by the symbol "+." The code descriptor of an AOC generally includes phrases such as "each additional" or "(List separately in addition to primary procedure)."

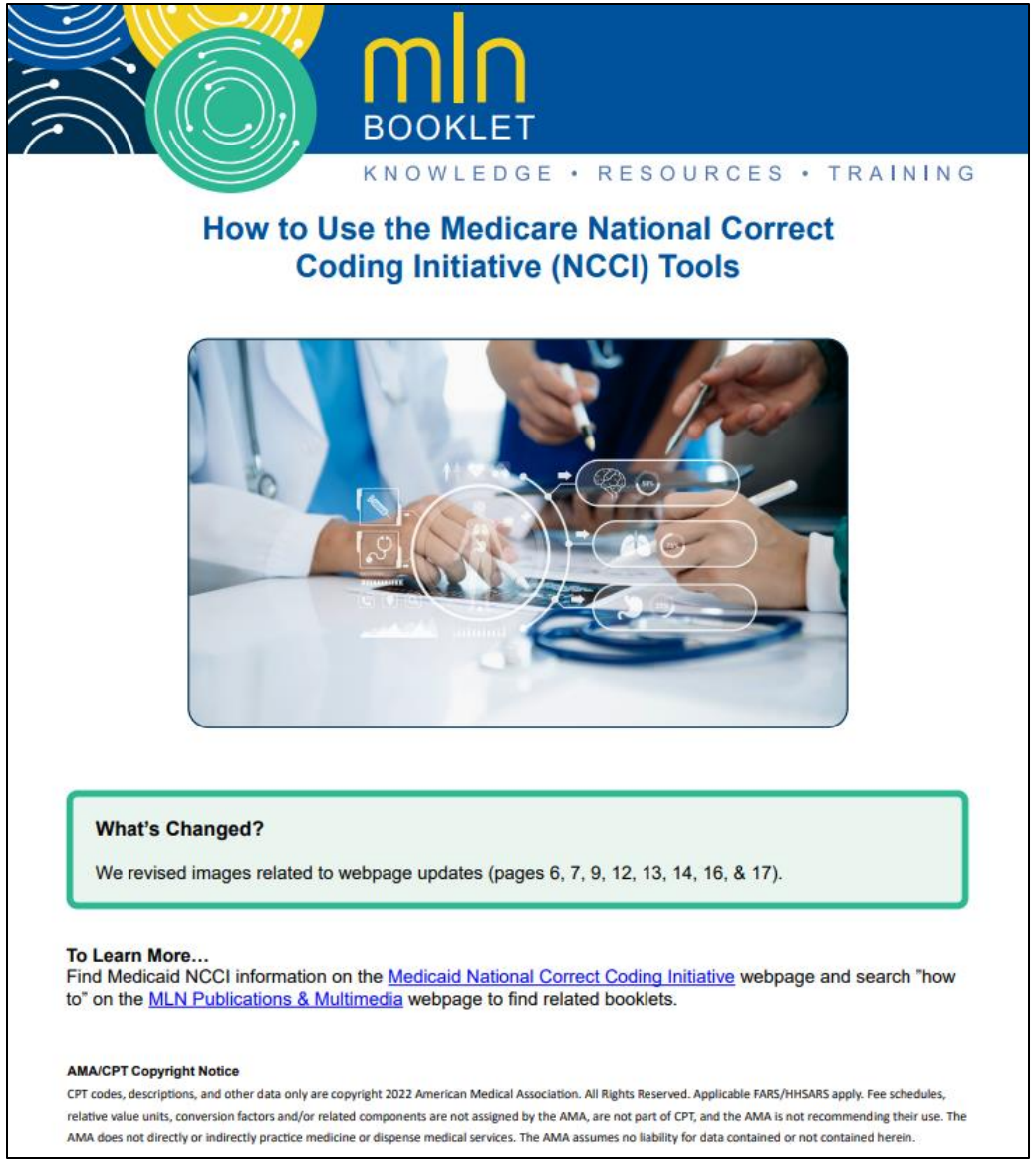
AOC File Example

- **Provider is billing for CPT code 96158 and 96159:**
  - Code pair is listed as an AOC type 1
  - AOC code is 96159
  - Primary code is 96158
  - Edit was effective 01/01/2020

	A	B	C	D	E	F	G	H
1	AOC_Edit_Type	Add_On-Code	AOC_DelDt_Julian	Primary_Code	Primary_Code _DelDt_Julian	AOC_Edit_EffDt-Julian	AOC_Edit_DelDt-Julian	Special_Instruction/Notes
7630	1	96137		96136		2019001	2019001	(Temporarily suspended retroactive to 1/1/2019)
7631	1	96139		96138		2019001	2019001	(Temporarily suspended retroactive to 1/1/2019)
7632	1	96159		96158		2020001		
7633	3	96160		99201	2020366	2017001	2020366	

How to Use the Medicare NCCI Tools

- CMS has a step-by-step process on the Medicare National Correct Coding Initiative (NCCI)



mln BOOKLET

KNOWLEDGE • RESOURCES • TRAINING

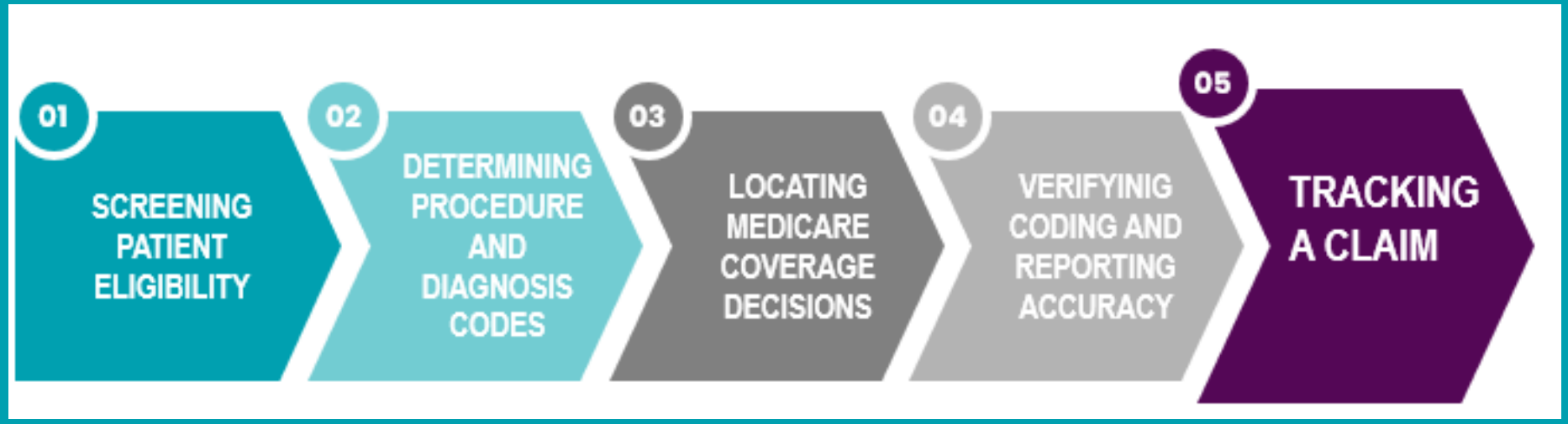
How to Use the Medicare National Correct Coding Initiative (NCCI) Tools

What's Changed?

We revised images related to webpage updates (pages 6, 7, 9, 12, 13, 14, 16, & 17).

To Learn More…
Find Medicaid NCCI information on the Medicaid National Correct Coding Initiative webpage and search "how to" on the MLN Publications & Multimedia webpage to find related booklets.

Tracking a Claim



Mandatory Electronic Claim Submission

- Providers are required to submit claims to Medicare when they provide services to a Medicare beneficiary
- **Background:**
  - Administrative Simplification Compliance Act (ASCA) requirements:
    - Requires that all initial claims for reimbursement under Medicare, except for small providers, be submitted electronically, with limited exceptions
- **Purpose:**
  - **Medicare will not accept claims submitted on paper that do not meet the limited exception criteria:**
    - Claims denied for this reason will contain a claim adjustment reason code and remark code indicating that the claim will not be considered unless submitted via an electronic claim
    - One exception is for provider of services with fewer than 10 full-time equivalent employees

Claim Filing Time Limits

- **Purpose:**
  - A claim must be filed with the appropriate Medicare contractor on a form/electronic equivalent prescribed by CMS in accordance with CMS instructions
- **Definition:**
  - Part B claims must be submitted no later than 12 months, or one calendar year, after the date the service(s) were furnished
  - MSP claims do not receive timely filing extensions
  - Claims received by the contractor without an explanation for the late filing are generally assumed to be filed late and the provider accepts responsibility for late filing

Claim Filing Time Limit Exceptions

- **Medicare regulations cited within 42 CFR §424.44(b) allow for the following exceptions to the one calendar year time limit for filing fee for service claims:**
  - Administrative errors
  - Retroactive Medicare entitlement
  - Retroactive Medicare entitlement involving State Medicaid Agencies
  - Retroactive disenrollment from a Medicare Advantage Plan
- The Medicare contractor has responsibility for determining whether a late claim may be processed based on all pertinent documentation submitted by the provider or supplier
- **References:**
  - Medicare Claims Processing Manual, Pub. 100-04, Chapter 1 – General Billing, Section 70 "Timely Filing Period"
  - Medicare Claims Processing Manual, Pub 100-04, Chapter 1 – General Billing Requirements, Section 70.7 "Exceptions Allowing Extension of Time Limit"

Payment Floors

- **Definition:**
  - The “payment floor” establishes a waiting period during which time the contractor may not pay, issue, mail, or otherwise finalize the initial determination on a clean claim
  - A “clean” claim is one that does not require the Medicare Administrative Contractors (MACs) to investigate or develop on a prepayment basis
- **Purpose:**
  - **The “payment floor date” is the earliest day after receipt of the clean claim that payment may be made:**
    - Electronic claims - 14 days from date of receipt of claim
    - Paper claims - 29 days from date of receipt of claim
  - Medicare has 30 days to pay the claim but cannot pay before the expiration of the payment floor
- Avoid duplicate submissions and allow sufficient time for a claim to process and check status of the claim prior to resubmitting the claim
- Medicare Claims Processing Manual, 100-04, Chapter 1 – General Billing Requirements, Section 80.2 “Definition of Clean Claim”

Additional Documentation Request (ADR) Process

- Additional development requests (ADR) are used to collect and clinically review medical records and related information to ensure that payment is made only for services that meet all Medicare coverage, coding, billing and medical necessary requirements
- **An ADR is generated by the contractor when documentation is necessary to support a Medicare claim:**
  - The request is for medical record documentation to support payment of an item(s) or service(s) reported generated when documentation is necessary
  - Includes a description of the type of documentation that is needed, along with the date of service
  - Provider has 45 days to submit medical records to support services:
    - Return records with the ADR request as a cover sheet using one of the submission options outlined in the request
- **Documentation may be received by your MAC:**
  - US Mail
  - Electronic Submission of Medical Documentation (esMD)
  - Fax
  - CD/DVD
  - MAC designated provider portal
- **Reference:**
  - Medical Review ADR process

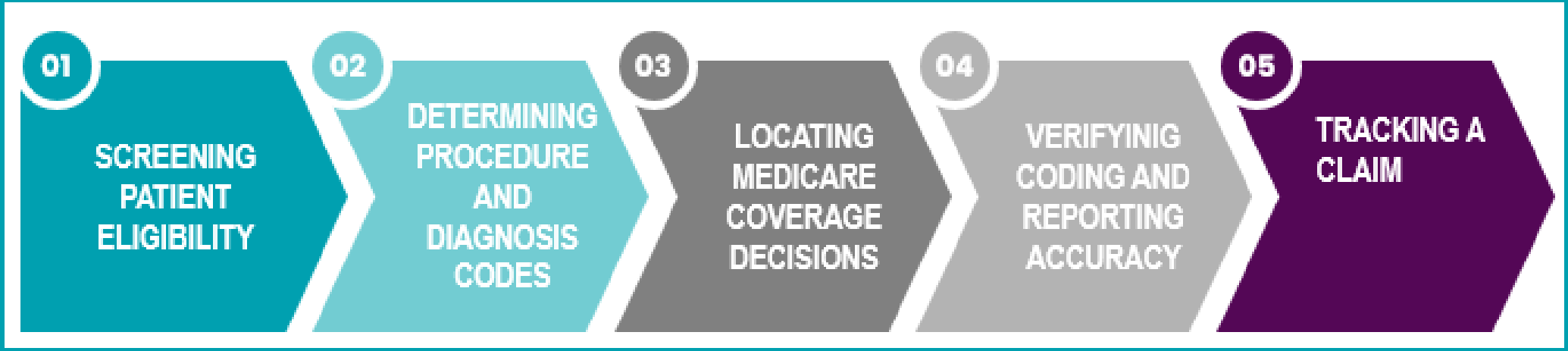
Claims Processing

- **Claims submitted for Medicare reimbursement consideration will be processed under the following potential outcomes:**
  - **Approved to pay:**
    - A claim determination for a service/item covered by Medicare resulting in Medicare reimbursement
  - **Denial:**
    - **A claim determination showing the service/item is not covered by Medicare:**
      - Resolution: Determine the reason for denial from remittance advice
  - **Rejection:**
    - **No claim determination can be made:**
      - Resolution: Correct and resubmit

Obtaining Claim Status

- Once a claim is submitted for processing and is assigned a Control Number there are easy and affordable ways to track claims processing
- **Several options are available:**
  - Medicare Administrative Contractor (MAC) online provider portal
  - MAC Interactive Voice Response (IVR) system
  - Remittance Advice (RA):
    - Paper or electronic
- These tools can also assist with determining why a claim was returned, denied, or rejected and assist with trying to prevent the claim submission error from occurring the next time

A Step-by-Step Scenario



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Step 1: Screening Patient Eligibility

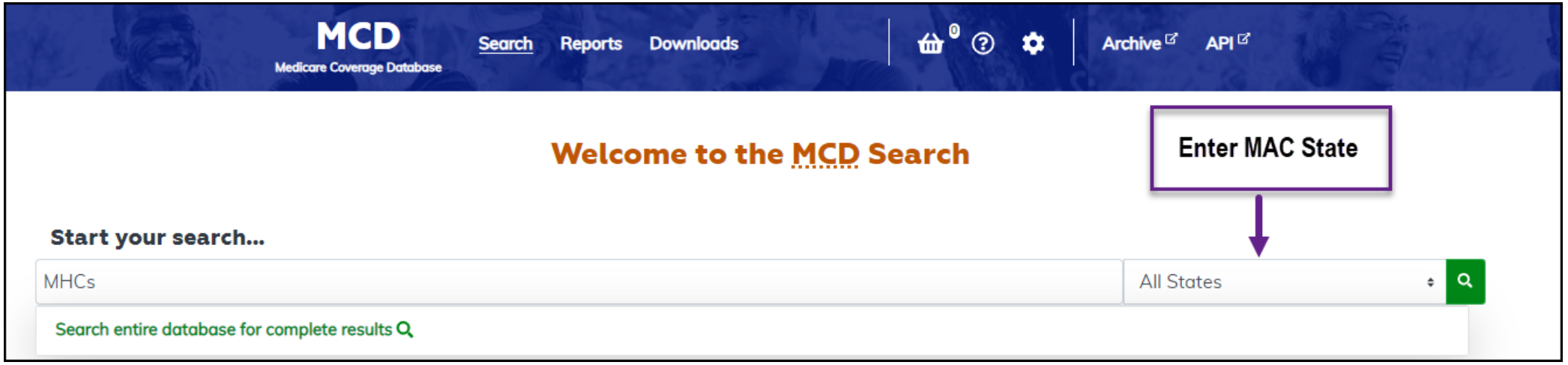
- A patient has been referred to an MHC for a health behavior assessment and intervention
- **Step 1 - screen the patient for eligibility:**
  - **The MAC Portal:**
    - ➢ The patient is entitled to Medicare Part B and does not have a Medicare Advantage Plan (MAP) on file
    - ➢ The patient has met his 2024 deductible
    - ➢ The MSP information reflects that Medicare is primary
    - ➢ **There is no home health certification or care on file and the patient is not enrolled in Hospice:**
      - ❑ It is best practice to ask the patient if anyone is coming to their home to assist with his or her care as beneficiaries are often not familiar with this terminology

Step 2: Determining the Appropriate Procedure and Diagnosis Code

- **The MHC is providing a health behavior assessment:**
  - ICD-10-CM is the standard transaction code set for diagnostic purposes:
    - Verify the code prior to submitting the claim
- **Documentation supports these two codes:**
  - CPT 96158– Health behavior intervention, individual, face-to-face; initial 30 minutes
    - This service was performed for 30 minutes
  - CPT 96159 – Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
    - This service was performed for 12 minutes
- **Total time of the health behavior intervention was 42 minutes:**
  - CPT code 96158 requires face-to-face time with the patient for 30 minutes:
    - Report procedure codes for services delivered on a single calendar day using CPT code and a unit of service of "1"
  - CPT code 96159 is an add on code that must be reported with the primary code (96158) when more than 30 minutes of time is spent providing this type of service to the patient:
    - Report procedure codes for services delivered on a single calendar day using CPT codes and a unit of service of "1"
    - Services provided for a single timed CPT code that is less than 8 minutes should not be billed

Step 3: Locating a Medicare Coverage Policy

- Medicare Coverage Database Search
  - Enter Keyword and select the MACs state
  - Page will show any NCDs, LCDs and LCAs for the contract selected
  - Select the document type
  - Hit apply



Step 4: Verifying Coding and Reporting Accuracy

- **The provider is billing for CPT codes 96158 and 96159:**
  - Column A shows the code pair is listed as an AOC type 1
  - Column B lists the AOC code 96159
  - Column D lists the primary code 96158
  - Column F advises that the edit was effective 01/01/2020
- AOCs are services eligible for payment if they are reported with the primary procedure on the same claim for the same date of service

	A	B	C	D	E	F	G	H
1	AOC_Edit_Type	Add_On-Code	AOC_DelDt_Julian	Primary_Code	Primary_Code _DelDt_Julian	AOC_Edit_EffDt-Julian	AOC_Edit_DelDt-Julian	Special_Instruction/Notes
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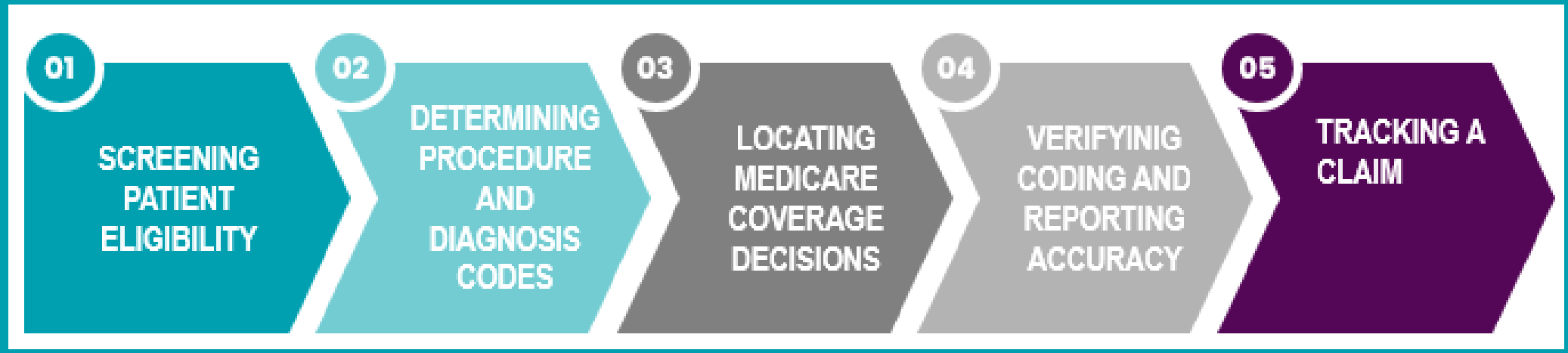
7632	1	96159		96158		2020001		
7633	3	96160		99201	2020366	2017001	2020366	

Step 5: Tracking the Claim

- **Once the claim is submitted for processing and is assigned a Control Number you should begin to track the claim:**
  - **Several options are available:**
    - MAC online provider portal
    - IVR
    - RA:
      - Paper or electronic
  - **The "payment floor date" is the earliest day after receipt of the clean claim that payment may be made:**
    - Electronic claims - 14 days from date of receipt of claim
    - Paper claims - 29 days from date of receipt of claim
  - Medicare has 30 days to pay the claim but cannot pay before the expiration of the payment floor
- **Reference:**
  - Claim Status Request and Response

Helpful Resources



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How can providers obtain assistance with Medicare-related questions?

Contact the MAC

- Engage the Customer Contact Center
- Use web chat
- Submit a general inquiry

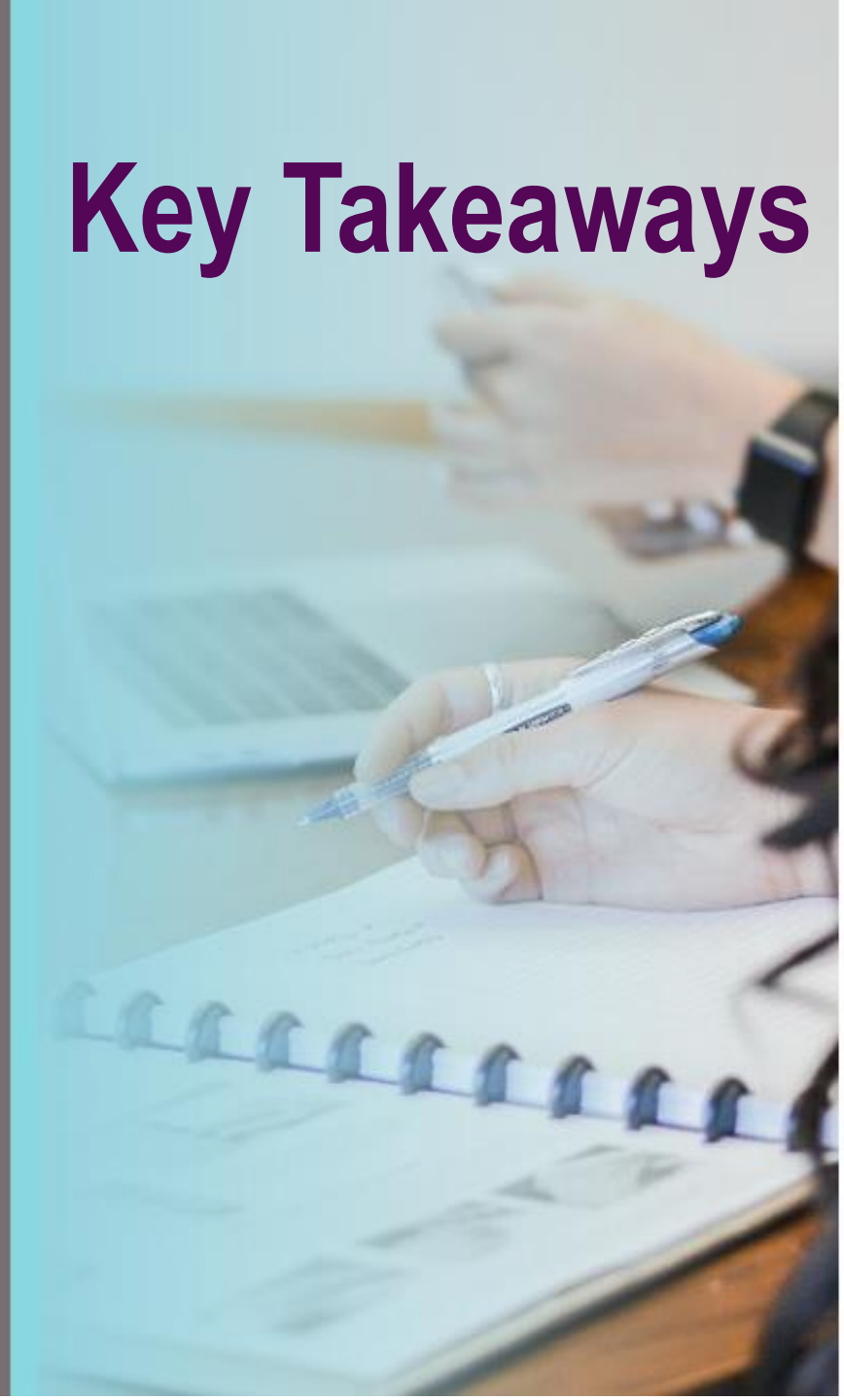
Use Resources

- Review the MAC and CMS websites
- Utilize self-service tools

Stay in the Know

- Participate in education
- View on-demand resources
- Sign up for email listservs/ notifications

Key Takeaways



01 All providers/practitioners should screen their Medicare patients to obtain correct health insurance information before submitting a claim to Medicare

02 MFTs and MHCs can bill Medicare independently for their services furnished for the diagnosis and treatment of a mental illness

03 All covered services must be medically reasonable and necessary to diagnosis and treat a beneficiary's condition

04 Primary and applicable AOCs must be submitted on the same claim for the same date of service

05 Check claim status prior to resubmitting a claim

Thank You

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Questions and Answers

Resources

Critical Resources on Medicare Part B Coverage of Counselors and MFTs

Legislation Mandating Medicare Part B Coverage of Counselors and Marriage and Family Therapists

https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf

How to Enroll in the Medicare Program

- **Medicare Enrollment for Providers and Suppliers**
  https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos
- **New Provider Type: Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) FAQs (36 questions answered) Published Sept 2023**
  https://www.cms.gov/files/document/marriage-and-family-therapists-and-mental-health-counselors-faq-09052023.pdf
- **The Medicare Learning Network:**
  https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlngeninfo
- **Web-based Training:**
  https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/webbasedtraining
- **Becoming a Medicare Provider (World of Medicare):**
  https://www.cms.gov/Outreach-and-Education/MLN/WBT/MLN9329634-WOM/WOM/index.html
- **Weekly Email Newsletter for Medicare Providers:**
  https://www.cms.gov/outreach-and-education/outreach/ffsprovpartprog/provider-partnership-email-archive

Critical Resources on Medicare Part B Coverage of Counselors and MFTs continued

Role of the Centers for Medicare and Medicaid Services (CMS)

- https://www.investopedia.com/terms/u/us-centers-medicare-and-medicaid-services-cms.asp
- https://www.cms.gov/outreach-and-education/outreach/ffsprovpartprog/provider-partnership-email-archive

Medicare Mental Health Benefits for Beneficiaries

Medicare and Your Mental Health Benefits:
https://www.medicare.gov/Pubs/pdf/10184-Medicare-and-Your-Mental-Health-Benefits.pdf

Medicare Mental Health:
https://www.cms.gov/files/document/mln1986542-medicare-mental-health.pdf

Medicare Beneficiary Handbook:
https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf

Critical Resources on Medicare Part B Coverage of Counselors and MFTs continued

Medicare Administrative Contractors (MACs)

https://www.cms.gov/medicare/medicare-contracting/medicare-administrative-contractors/what-is-a-mac

Medicare Physician Fee Schedule

https://www.federalregister.gov/documents/2023/08/07/2023-14624/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other

Key Steps to Becoming a Medicare Provider

1. Register in the I&A System
2. Get an NPI
3. Enter information into PECOS
4. Decide if you want to be a participating provider

Form CMS-855I: Physicians and non-physician practitioners (PDF link)


Thank you
for attending!
Medicare Mental Health
Workforce Coalition