Defining, Locating, and Using Medi Coverage Policies

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Polling #1

How would you rate your knowledge about “Defining, Locating, and
Medicare Coverage Policies”, prior to today’s presentation?

A. Very Unknowledgeable
B. Somewhat Unknowledgeable
C. Neither Knowledgeable or Unknowledgeable
D. Somewhat Knowledgeable
E. Very Knowledgeable

Defining Coverage Policies

Hierarchy of Medicare Regulations

- Social Security Act
- Code of Federal Regulations (CFR)
- CMS' Rulings
- Coverage Provisions in Internet-Only Manuals (IOM)
- National Coverage Determination (NCD)
- Change Requests (CRs)
- MACs' Local Coverage Determination (LCD)
- MACs' Local Coverage Articles (LCA)

What Is a Coverage Policy?

- Definition:
  - Developed to describe circumstances for Medicare coverage locally nationwide for an item or service
- Purpose:
  - Generally, outlines conditions for which an item or service is conside covered (or not covered) under §1862(a) (1) of the Social Security A applicable provisions of the Act

Coverage Policy Details

- Information that may be contained in a coverage policy includes:
  - Description Information:
    - Benefit category
    - Item/service description
    - Indications and limitations of coverage and/or medical necessit
    - Claims processing instructions
  - National Coverage Analyses
  - Transmittal Information
  - Revision History
  - Additional Information
  - Procedure Codes
  - Covered and/or Non-Covered Diagnosis Codes

Coverage Policies—NCD

- NCD:
  - Developed by CMS
  - Binding on all contractors
  - Applies to all Medicare claims
  - Developed through an evidence-based process with opportunities fo input
  - Outside technology assessments and/or consultation with Medicare Development & Coverage Advisory Committee
- Reference:
  - Medicare National Coverage Determination Manual Pub. 100-03

Coverage Policies—LCD

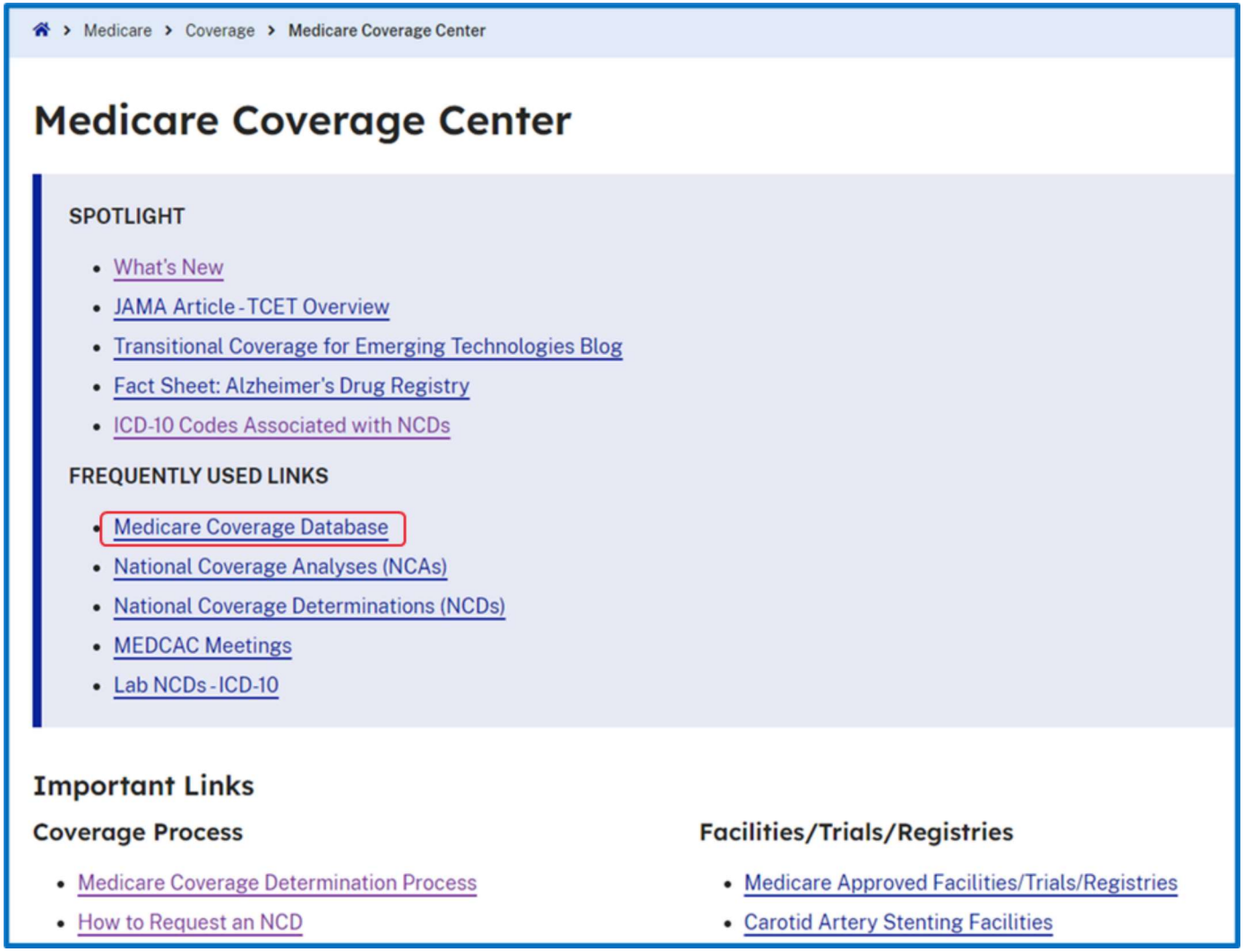
- LCD:
  - Developed by the MAC when:
    - Item or service is covered or not covered under certain circumstances
    - A problem is discovered that demonstrates a significant risk to the Medic fund
    - Item or service overutilization or misuse is detected
    - External party request (beneficiaries, providers, or manufacturers)
  - CPT/HCPCS, ICD-10 codes are not listed within the coverage policy
    - Local coverage article (LCA): Associated billing and coding article create CPT/HCPCS and ICD-10-CM codes
- Reference:
  - Medicare Program Integrity Manual Pub 100-08, Chapter 13—Loca Coverage Determinations

LCA Billing and Coding Articles

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

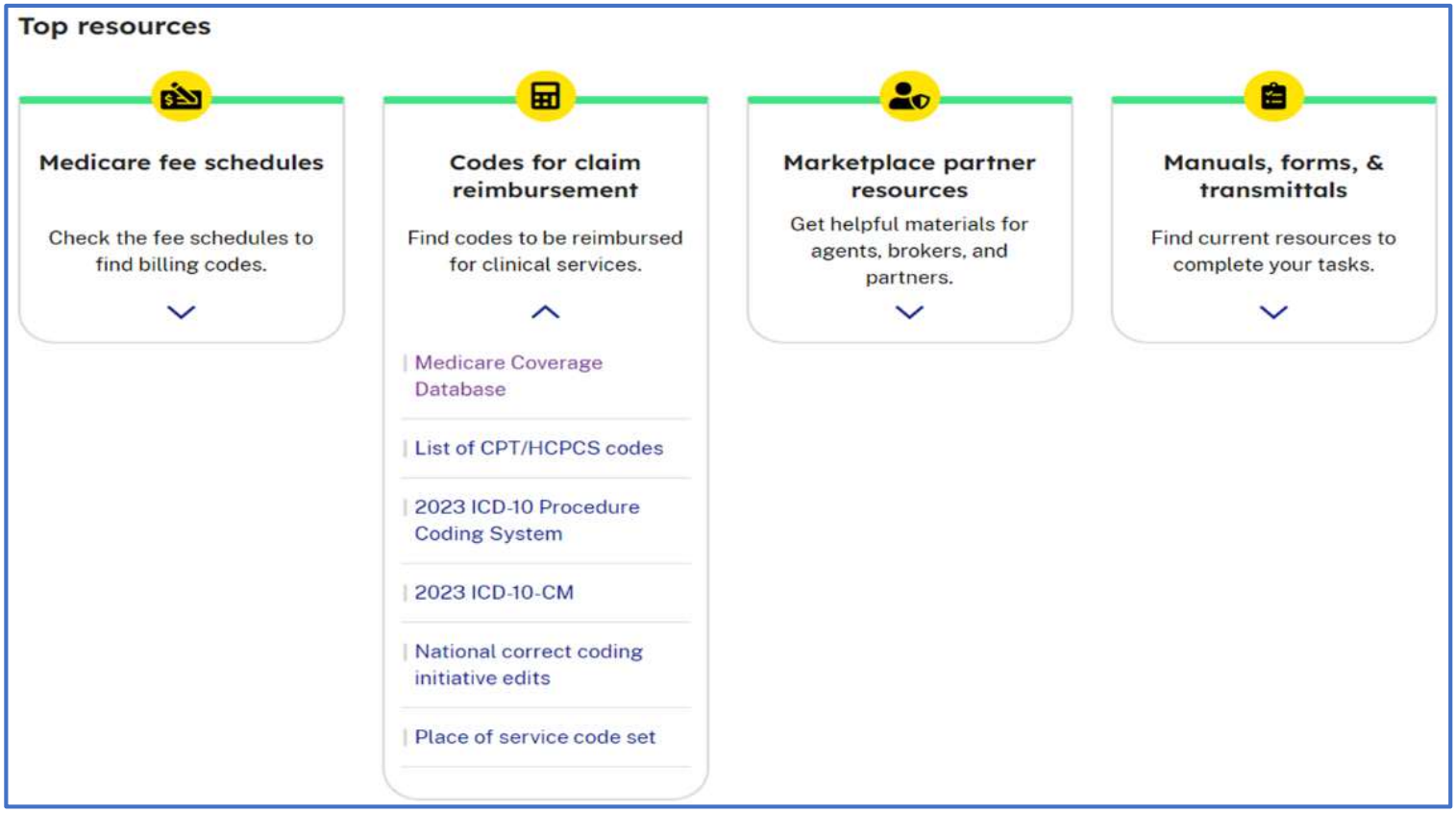
Locating Coverage Policies

CMS Website



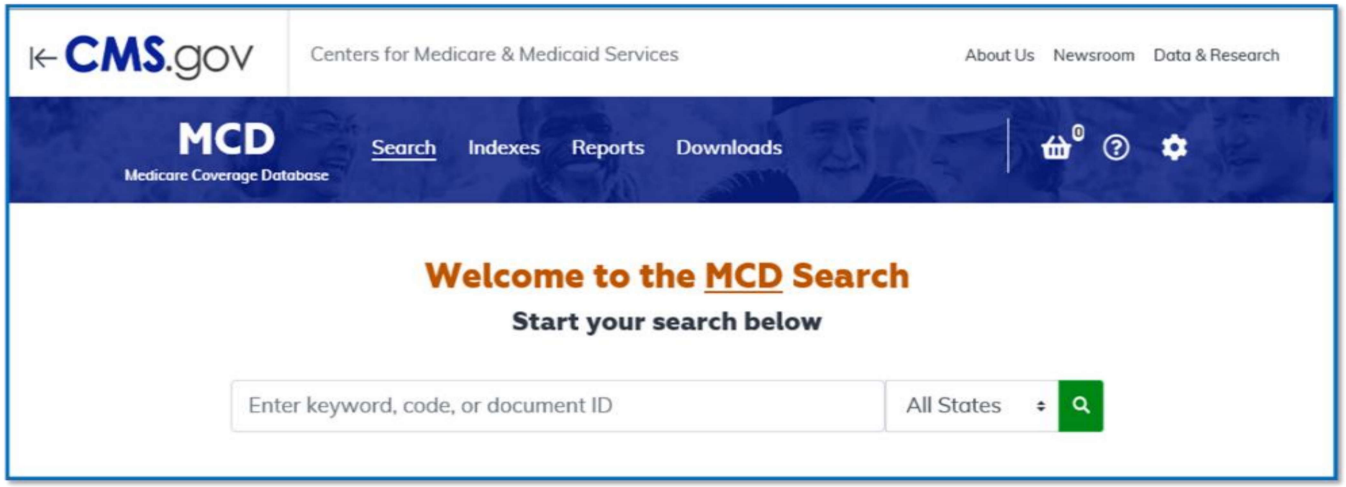
- Medicare Coverag

CMS Website



- Top resources:
  - Codes for clai reimbursemer
    - Medicare Databas

Searching for Coverage Policies



- Medicare Coverage
  - Search by:
    - Keyword
    - Code
    - Document ID
  - Select state
- References:
  - Medicare Learning (MLN) Matters Art MLN901347 “How Medicare Coverag Database”

Using Coverage Policies

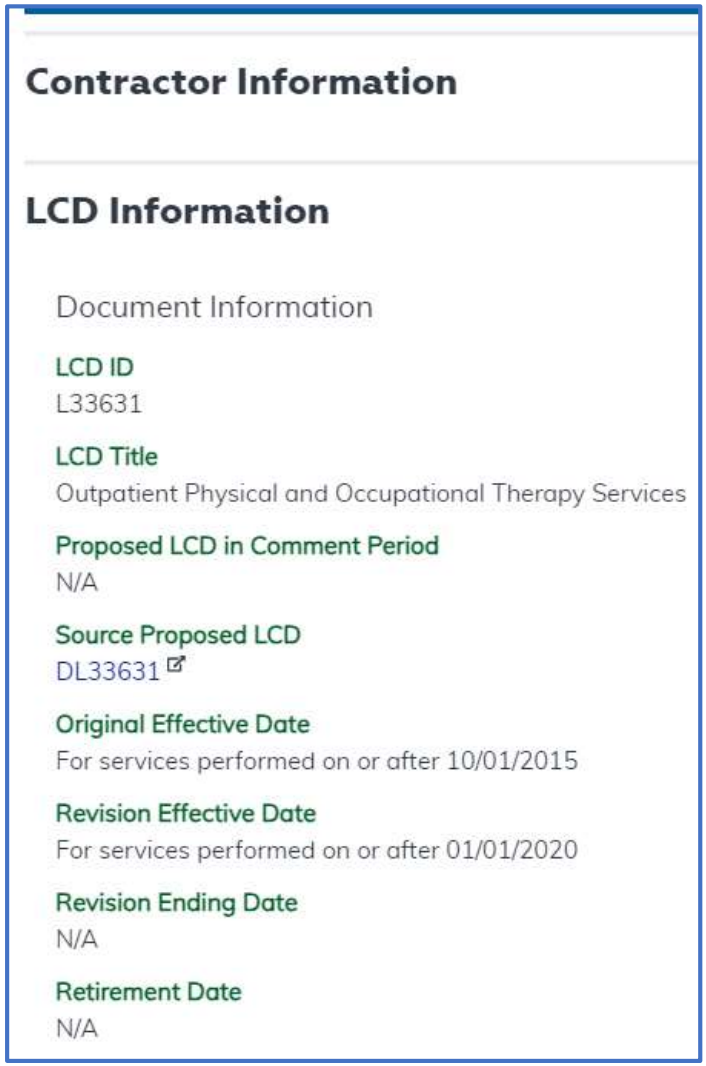
Benefits of Coverage Policies

- Administrative and educational tools to assist providers to submit claims for payment
- Help define Medicare coverage limitations for certain services
- Help reviewers make consistent, accurate coverage decisions
- NCDs supersede LCDs; however, an LCD may expand/clarify co and coding for an NCD

Claim Denials Are Costly

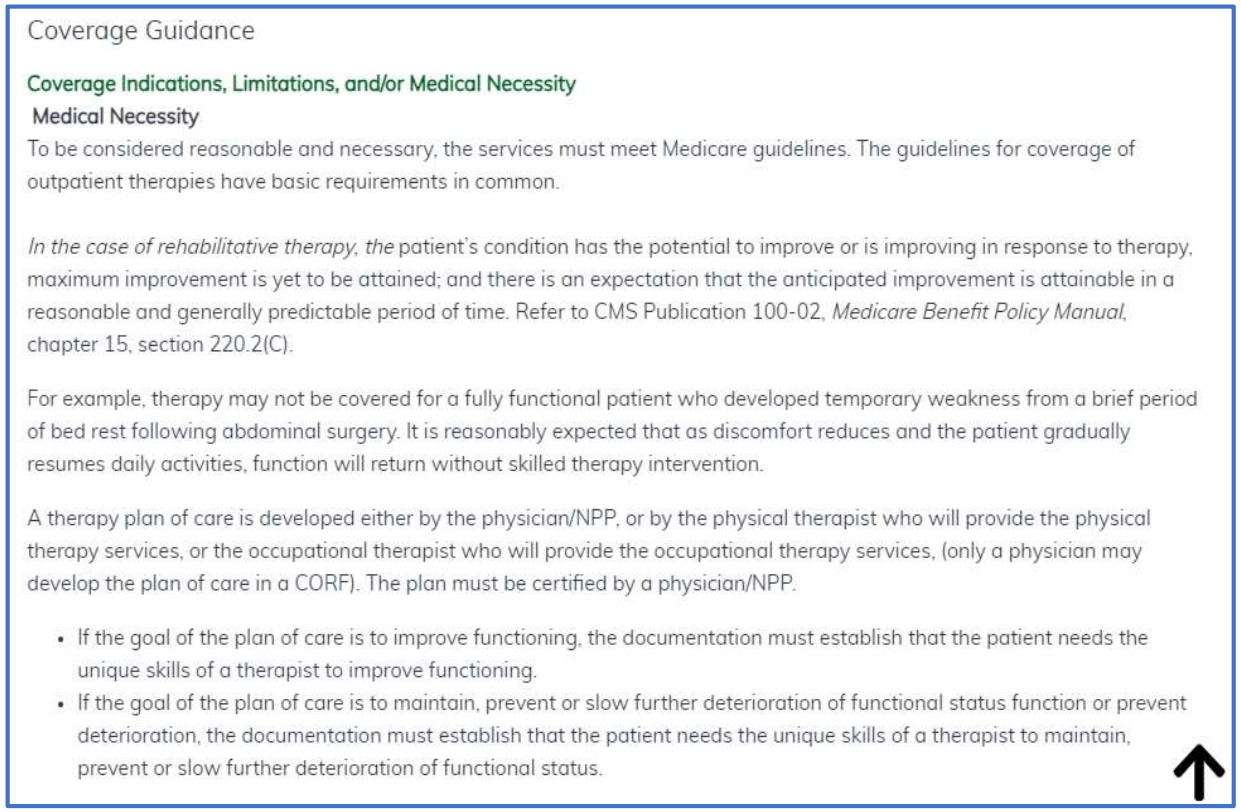
- Claim denials related to NCDs and LCDs make up a large percer of denied claims
- Denials represent a major expense to providers in terms of time and money
- To fix and prevent denials, providers must know how to access ar correctly interpret Medicare NCDs, LCDs, and other regulations

LCD Information



- Contractor information:
  - Drop down arrow displays applicable contractor
- LCD ID number:
  - The number of the medical policy
- LCD title:
  - Services policy is applicable to
- Effective date:
  - Date of service policy is effective for
- Revision date (if applicable):
  - Date of service policy is effective for
- Retirement date (if applicable):
  - Date policy is no longer active
    - Policy effective for claims with a prior date

Coverage Guidance



Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Medical Necessity

To be considered reasonable and necessary, the services must meet Medicare guidelines. The guidelines for coverage of outpatient therapies have basic requirements in common.

In the case of rehabilitative therapy, the patient's condition has the potential to improve or is improving in response to therapy, maximum improvement is yet to be attained; and there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time. Refer to CMS Publication 100-02, *Medicare Benefit Policy Manual*, chapter 15, section 220.2(C).

For example, therapy may not be covered for a fully functional patient who developed temporary weakness from a brief period of bed rest following abdominal surgery. It is reasonably expected that as discomfort reduces and the patient gradually resumes daily activities, function will return without skilled therapy intervention.

A therapy plan of care is developed either by the physician/NPP, or by the physical therapist who will provide the physical therapy services, or the occupational therapist who will provide the occupational therapy services, (only a physician may develop the plan of care in a CORF). The plan must be certified by a physician/NPP.

- If the goal of the plan of care is to improve functioning, the documentation must establish that the patient needs the unique skills of a therapist to improve functioning.
- If the goal of the plan of care is to maintain, prevent or slow further deterioration of functional status function or prevent deterioration, the documentation must establish that the patient needs the unique skills of a therapist to maintain, prevent or slow further deterioration of functional status.

- Coverage indications, li
  and/or medical necessit
  - Eligible providers to p
    services
  - Number of times the s
    be performed
  - Under what condition
    services are covered
- Summary of evidence
- Analysis of evidence

Indications and Limitations

Indications and Limitations of Coverage and/or Medical Necessity for specific modalities and procedures:

Therapy services should be provided in a manner that meets the patient's needs. The treatment plan should strive to provide treatment in the most efficient and effective manner, balancing the best achievable outcome with the appropriate resources. This LCD provides recommendations intended to assist qualified professionals/auxiliary personnel in documenting to support both the medical necessity and the skilled nature of the therapy services provided. In addition, any numerical guidelines related to individual codes in this section of the LCD, are based on contractor medical review experience. These are provided to remind qualified professionals/auxiliary personnel of the importance of justifying therapy services in the documentation as the patient progresses through an episode of care. Documentation must be sufficient to demonstrate the specifics of the therapy provided so that it may be determined that the treatment was medically necessary. Please refer to CMS publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, section 220.3 for the Medicare minimal documentation requirements for therapy services.

Physical therapy evaluation

Occupational therapy evaluation

The initial evaluation should document the necessity of a course of therapy through objective findings and subjective patient/caregiver self-reporting. Initial evaluations must be completed by the therapist or physician/NPP that will be providing the therapy services. Initial evaluations are completed to determine the medical necessity of initiating rehabilitative therapy or skilled instruction in maintenance activities that the patient and/or caregiver can perform at home.

- Provides co
and/or mec
necessity fo
modalities
procedures

Miscellaneous Services

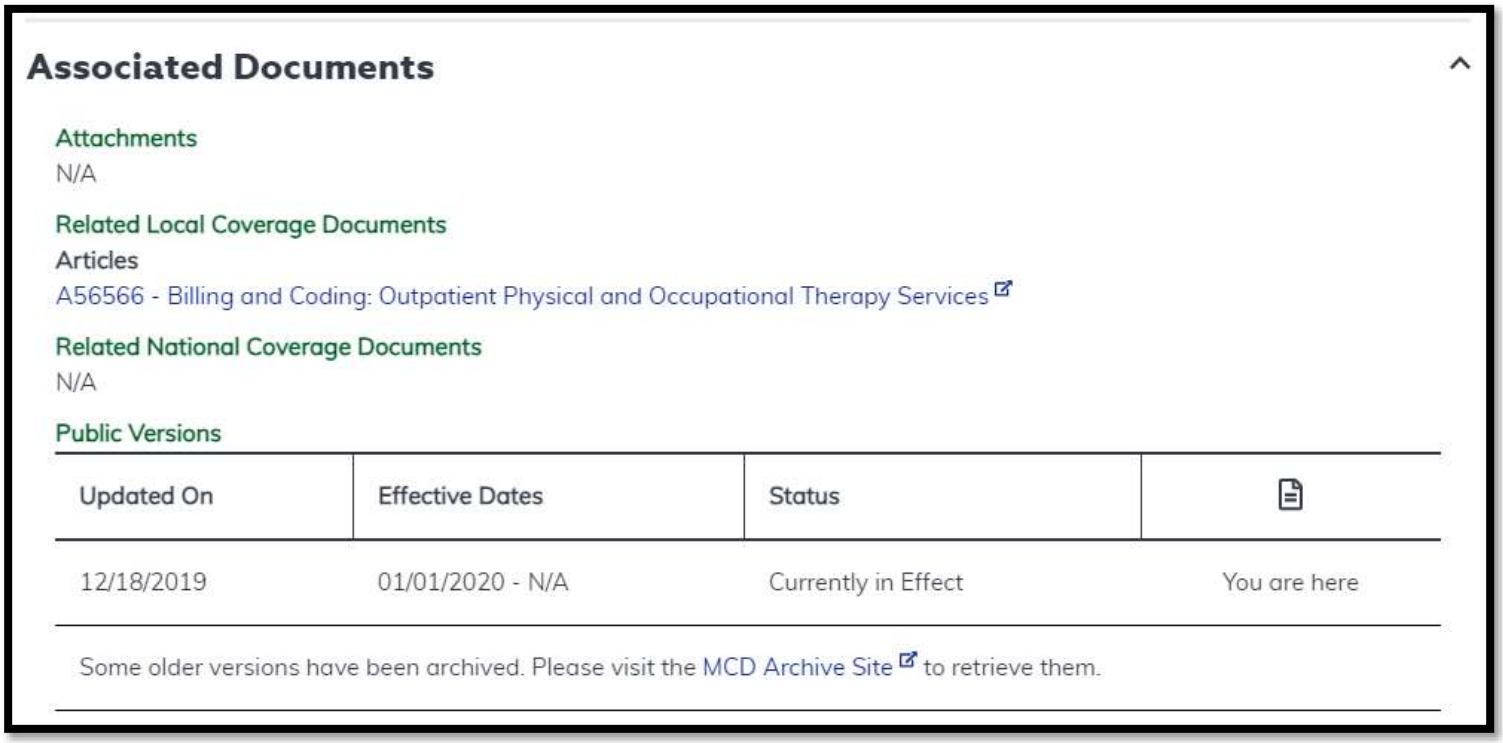
Miscellaneous Services (Non-covered)

The following are non-covered as skilled therapy services. This is not an all inclusive list.

- Iontophoresis, except as indicated for primary focal hyperhidrosis
- Anodyne
- Low level laser treatment (LLLT)/cold laser therapy
- Dry hydrotherapy massage (e.g., aquamassage, hydromassage, or water massage)
- Massage chairs or roller beds
- Interactive metronome therapy
- Loop reflex training
- Vestibular ocular reflex training
- Continuous passive motion (CPM) device setup and adjustments
- Craniosacral therapy
- Electro-magnetic therapy, except as indicated for chronic wounds
- Constraint Induced Movement Therapy (CIMT)
- Work-hardening programs
- Pelvic Floor Dysfunction (not including incontinence)
    - Due to the lack of peer reviewed evidence concerning the effect on patient health outcomes, skilled therapy interventions (e.g., ultrasound, electrical stimulation, soft tissue mobilization, and therapeutic exercise) for the treatment of the following conditions is considered investigational and thus non-covered.
        - pelvic floor congestion
        - pelvic floor pain not of spinal origin
        - hypersensitive clitoris
        - prostatitis
        - cystourethrocele
        - enterocele
        - rectocele
        - vulvodynia
        - vulvar vestibulitis syndrome (VVS)

- Some policies a listing of non services

Associated Documents



Associated Documents

Attachments
N/A

Related Local Coverage Documents
Articles
A56566 - Billing and Coding: Outpatient Physical and Occupational Therapy Services

Related National Coverage Documents
N/A

Public Versions

Updated On	Effective Dates	Status	
12/18/2019	01/01/2020 - N/A	Currently in Effect	You are here

Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.

- Locate links to:
  - Attachments
  - Related local documents/a

LCA

General Documentation Requirements

The patient's medical record must contain documentation that fully supports the medical necessity for services included within the LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures, the time of any assessment is included and billed within the appropriate treatment intervention CPT code. *Therapy services shall be payable when the medical record and the information on the claim consistently and accurately report covered therapy services. Documentation must be legible, relevant and sufficient to justify the medical necessity of the services billed.* Medicare requires a legible identifier of the person(s) who provided the service. The method used shall be a hand written or an electronic signature to sign an order or other medical documentation for medical review purposes. Electronic or hand written signatures that have been communicated through facsimile are also acceptable. Effective April 28, 2008, stamp signatures were no longer acceptable. The document guidelines in CMS Pub 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 220 and 230 identify the minimal expectations of documentation by providers or suppliers or beneficiaries submitting claims for payment of therapy services to the Medicare program. It is encouraged, in order to support the medical necessity and the skilled nature of the treatment, to document more thoroughly and frequently. Medical review decisions are based on the information submitted in the medical record. Therefore, it is critical that the medical record information submitted is accurate and complete to allow medical review to make a fair payment decision. The medical record information submitted should:

- Paint a picture of the patient's impairments and functional limitations requiring skilled intervention;
- Describe the prior functional level to assist in establishing the patient's potential and prognosis;
- Describe the skilled nature of the therapy treatment provided;
- Justify that the type, frequency and duration of therapy is medically necessary for the individual patient's condition;
- Clearly document both Timed Code Treatment Minutes and Total Treatment Time in order to justify the units billed;
- Identify each specific skilled intervention/modality provided to justify coding.

- Includes:
  - CPT/HCPCS
  - ICD-10 codes
  - General docum requirements
  - Supportive doc requirements
  - Links back to a LCD

No Coverage Policy

- No active NCD, LCD, or LCA:
  - Check for coverage guidelines in CMS manuals, change requests (C
    Medicare Learning Network (MLN) Matters® articles
  - Check the associated MAC website
  - Check for related medical policy article
  - Make sure the service is not statutorily or administratively excluded
  - Adhere to medical necessity guidelines
- Reference:
  - Medicare Benefit Policy Manual Pub. 100-02, Chapter 16, "General
    From Coverage"
  - CMS Medicare Coverage Determination Process

Polling #2

How would you rate your knowledge about “Defining, Locating, and Medicare Coverage Policies”, following today’s presentation?

A. Very Unknowledgeable
B. Somewhat Unknowledgeable
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D. Somewhat Knowledgeable
E. Very Knowledgeable

Questions

You can also send your questions to the medicaremedicalreview@cms.hhs.gov box at any time.