CAC AND PIAC UPDATES

SARAH ABSHIER & ANIMESH BHATIA

PRIVATE INSURANCE-AETNA

- In July Aetna dropped its external review program regarding the use of -59 modifier when submitted with CPT 11719-11721, G0127, 11055-11057.

- Aetna had been inappropriately applying an edit to certain foot care claims.

APMA.org/59Mod

PRIVATE INSURANCE-CIGNA

- CIGNA did an about face on their attempt to require physician notes whenever a -25 modifier was being utilize.

UPDATES ON CGS MEDICARE

- CMS and/or its Part B Contractors are recouping money from providers who submitted services that were performed for patients who were under a long-term nursing facility stay (Place of Service 32), using Place of Service 31 (Skilled Nursing Facility).

APMA COMMENTS

These recoupments appear to be happening to many different provider types and throughout the country. APMA staff, committees, and consultants are collecting information and strategizing an approach to CMS to discuss the fairness and appropriateness of these recoupments

APMA COMMENTS

Members who receive such a recoupment are encouraged to contact their administrative defense coverage carrier immediately.

CMS AND OIG EXPLANATION

https://oig.hhs.gov/oas/reports/region4/42104084.asp

- **How OIG Did This Audit**
- For calendar years 2019 and 2020, identified 2.1 million physician service claim lines at risk of overpayment because of non-compliance with the place-of-service policy. OIG conducted claims analysis and calculated the overpayments and potential overpayments, also discussed coding with CMS and practitioners and reviewed a sample of medical records.
- **What OIG Found**
- Medicare sometimes paid higher nonfacility rates rather than lower facility rates for physician services while enrollees were Part A SNF or hospital inpatients. During the 2-year audit period, Medicare made overpayments totaling $22,463,193 for 1,130,182 claim lines by paying the nonfacility rate for services coded as furnished in a nursing facility or SNF setting without Part A coverage while enrollees were a Part A SNF inpatients. CMS did not have Common Working File (CWF) system edits to detect these coding errors. Similarly, while enrollees were Part A SNF or hospital inpatients, Medicare paid an additional $22,142,489 for 1,012,203 physician service claim lines coded as furnished in a nonfacility setting.

RECOMMENDATIONS FROM APMA

- Do you see patients in a nursing facility? If so, it is important to include the correct place of service on claim forms.
- POS 32—"Nursing Facility"
- POS 31—"Skilled Nursing Facility"
- Oftentimes, the same facility may care for patients under both of these stay types. The onus is then placed on the provider to determine the correct place of service for every patient they care for. Patients who are under a POS 32 stay are typically in the facility for long-term care. Patients who are under a POS 31 stay have typically been transferred to a skilled nursing facility within 30 days of discharge from a medically necessary inpatient hospital admission of at least three consecutive days. Skilled nursing facility stays do not typically last more than 100 days.
- Because skilled nursing facility stays can potentially be fewer than 100 days, members are encouraged to rely on the patient's admission status with the facility to determine nursing facility versus skilled nursing facility status rather than relying only on the number of days of the stay.

MEDICARE

A medically reasonable and necessary repeat of CPT 11730/11732 of the same nail within 32 weeks of a previous avulsion will be **considered upon redetermination.**

Repeat CPT 11750 problem was fixed!

MEDICARE- NCCI

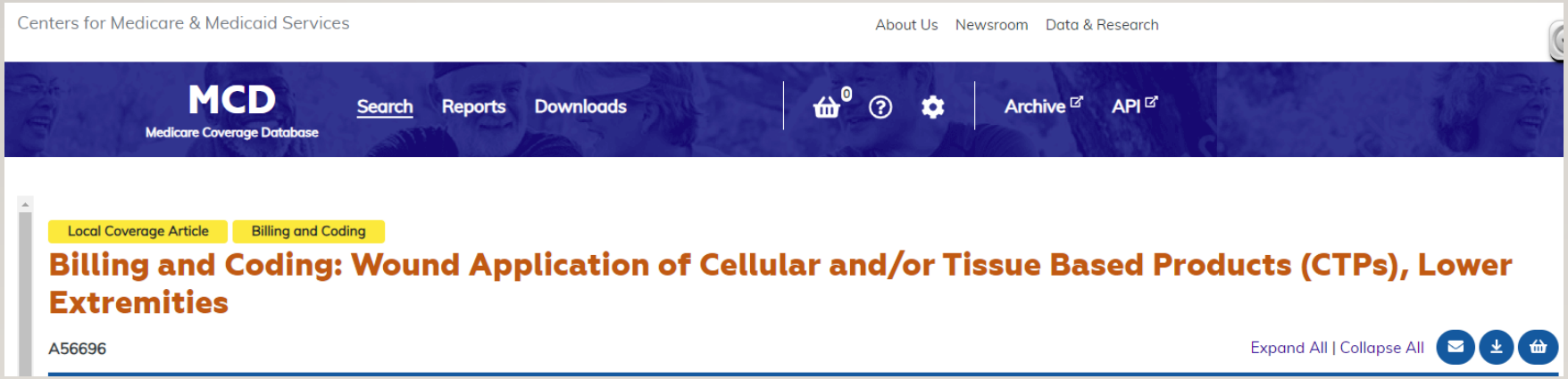
The Centers for Medicare & Medicaid Services' (CMS's) National Correct Coding Initiative (NCCI) program's has a new contractor!

SKIN SUBS & CTPS

- Medicare CGS LCD

  Current policy Effective 07/11/2019

  Revised 09/01/2022



SKIN SUBS & CTPS

- In 2022 there was proposed revised language to the LCD
- Late in 2022 an open comment period allowed interested parties to *comment*.
- August 2023 final proposed changes were published, effective date would be September 17th

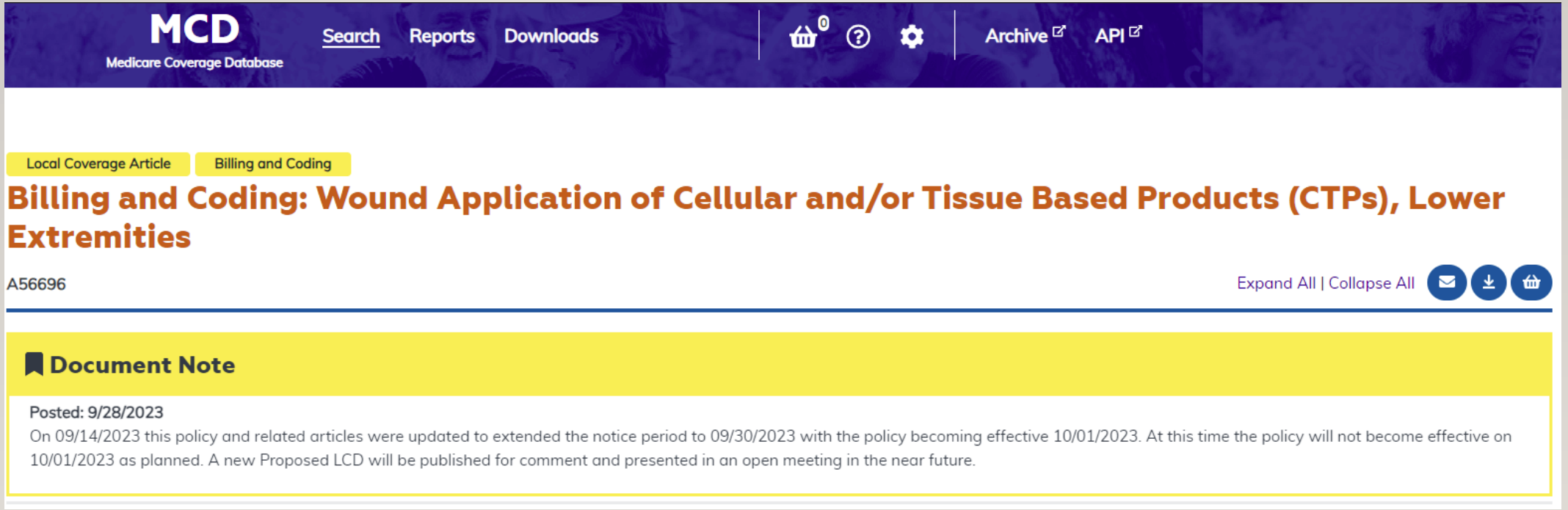
SKIN SUBS & CTPS

- After a whirlwind of *backlash* a "listening session" with CGS Medicare was scheduled for September 13 2023, just days before the planned implementation date of September 17th.

- Following the "listening session" the implementation date was pushed back to October 1st, 2023.

SKIN SUBS & CTPS

- September 28th



SKIN SUBS & CTPS
CGS LCD

https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=56696&ver=24&bc=0