Notes from the Palmetto GBA CAC Meeting

1. Policies that were presented as Drafts for comments – included the DL37779 Intraoperative Radiation Therapy
   This AB MAC LCD was updated to cover intraoperative radiation in the treatment of the following Cancers:
   - Breast
   - Colorectal
   - Uterine/Cervical
   - Soft Tissue Sarcomas

   The Palmetto representatives noted that the specific coverage conditions for each diagnosis are listed in the LCD and that SPECIFIC ICD-10 codes must be included on the claim for reimbursement.

2. A DRAFT coverage Molecular Diagnostics – known as ’MolDX’ for
   a. Breast cancer Index (BCI) Gene Expression Test
      i. This is an update of the policy based on evidence determined to be of High Strength, but of moderate quality
         1. BCI test is covered for postmenopausal women with invasive breast cancer when the following criteria are met
            a. ER+ and/or PR+ and HER2 neg invasive carcinoma of the breast
            b. Early stage disease (T1-3, N0, M0)
            c. No evidence of distant disease
            d. Test result will be used in determining treatment management of the patient for chemotherapy and/or extension (e.g. 5 vs 10 yrs) of endocrine therapy
         2. This is covered as a ‘once per lifetime’ event; however, a second test for contralateral new breast cancers are likely to be covered but will need appeal.

   b. Decipher Biopsy Prostate Cancer Classifier Assay for men with very low and low risk disease
      i. The Palmetto Medicare contractor will provide limited coverage for this test for men with NCCN low risk and very low risk prostate cancer only when the following conditions are met
         1. Needle biopsy with localized adenocarcinoma of the prostate
         2. FFPE prostate biopsy specimen with at least 0.5 mm of cancer length, and
         3. Pts with low or very low risk as defined by the NCCN
            a. Low Risk
               i. Stage T1 or T2a
               ii. PSA less than 10 ng/ml
               iii. Gleason score 6 or less (Grade group 1) OR
            b. Very low risk: Stage T1c
               i. PSA less than 10 ng/mL
               ii. Gleason score 6 or less (Grade Group 1)
               iii. Not more than 2 cores with cancer
               iv. Less than or equal to 50 % of core involved with cancer
               v. PSA density less than 0.15
         4. Life expectancy of >/= 10 yrs
5. Patient is a candidate for and considering conservative therapy and yet would be eligible for definitive therapy (radical prostatectomy, radiation therapy or brachytherapy)
6. Result will be used to determine treatment between definitive therapy and conservative management by active surveillance
7. Patient has not received pelvic radiation or androgen deprivation therapy prior to the biopsy
8. Patient is monitored for disease progression based on the established standard of care including at least a repeat biopsy at 1 year.

3. Presentation on Top 10 Medical Review Denials for Medicare Part B – most common to less common
   a. Information does not support medical necessity of services billed
   b. Claim billed in error per provider
   c. Information submitted contains an invalid or illegible provider signature
   d. Documentation requested for this date of service was not received or was incomplete (THIS DROPPED from #1 to #4 for the first time for JM area)
   e. Documentation received lacks the necessary time component
   f. Documentation received contains incorrect/incomplete/invalid patient Identification or Date of service
   g. Information submitted deemed illegible
   h. Documentation requested for this date of service was not received or was incomplete
   i. Documentation received lacks the necessary time component (Not clear how this differs from ‘e.’)

4. Presentation on Targeted Probe and Education process
   a. Palmetto indicated that this process is where the CMS medical review process is going to
      i. This process targets Reviews that are PROVIDER specific rather than the reviews that historically were more SERVICE specific as targets
      ii. Palmetto want to be sure that providers understand the new process
         a. Phase 1 MAC conducts data analysis to identify areas with the greatest risk of inappropriate program payment
            i. CMS may also identify areas
            ii. Providers are selected for review based on data analysis – not individual claims
               1. Analysis indicates aberrances that may suggest questionable billing practices
               2. May include providers previously reviewed on a targeted or service-specific review with high error rate
               3. NOTIFICATION LETTERS ARE MAILED TO PROVIDERS SELECTED FOR REVIEW
         iii. There are up to 3 rounds of review
             1. Limited to u20-40 claims per round.
             2. Rounds 2/3 will begin 45-56 days after the individual provider education is provided
                a. Discontinuation of review may occur if appropriate improvement and compliance is achieved during the review process
             3. ADR letters are generated for each claim selected
        4. DO NOT IGNORE THE ADR LETTERS – as a clock starts ticking
           a. Providers must respond to ADR within 45 days of the date of the letter
           b. INCLUDE THE CORRECT CONTACT PERSON AND INFORMATION on the response to the ADR letters – they do not have time to track the providers down and the clock keeps ticking,
5. At the conclusion of each round the medical reviewer will call provider with moderate to high error rate to discuss the summary of errors found
6. A letter with review results will be mailed to the provider

iv. When high denial rate continues after 3 rounds, provider will be referred to CMS

b. Palmetto recommended the following
   i. Note that CERT + CBR + MR = TPE – is what gets individual providers on the list
      1. CERT = Comprehensive Error Rate Testing (Where the error rate is essential the denial rate)
      2. CBR = Comparative Billing Report
         a. These show providers how they rank against their peers in the state and nationally in billing for certain risk areas
            i. This report is intended to be proactive statements to help the provider identify potential errors in their billing practices – PAY ATTENTION!!
      3. MR = Medical Review
      4. TPE = Targeted Probe and Education
   ii. Develop and utilize a checklist/audit/tracking tool to ensure compliance when responding to ADR request
   iii. There are no more service specific reviews….only provider specific
   iv. Do not ignore or misplace the request
   v. Make sure your address is up to date in the system
   vi. Make sure you have a designated person/team to receive the education for TPE
   vii. Pay close attention to your individual CBR report (Comparative Billing Reports)
   viii. Determine how your billing pattern variances may be addressed
   ix. Be sure that your documentation support the services billed.