CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

FIRST COAST
SERVICE OPTIONS, INC.
WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Medicare Part B Program Integrity
2020 Technology Park Way, Ste 100
Mechanicsburg, PA 17050

March 25, 2021

[redacted]

PTS Case Number: [redacted]
Provider NPI Number: [redacted]
PTAN: [redacted]

RE: Notice of Medical Review
Dear [redacted]

In order to fulfill our contractual obligation with the Centers for Medicare & Medicaid Services (CMS), First Coast, your Jurisdiction N, Medicare Administrative Contractor (MAC), performs reviews in accordance with the CMS instruction. CMS has authorized First Coast to conduct reviews utilizing a Service Specific review process.
The Centers for Medicare & Medicaid Services (CMS) utilizes Medicare Administrative Contractors (MAC) to review clinical documentation in order to reduce improper payments as per Social Security Act Sections 1833(e),1862(a)(1)(A) and 1842(p)(4). MACs choose claims for review based on many factors such as the service specific improper payment rate, data analysis, and billing patterns of the provider. CMS is cognizant that this type of review can be burdensome to providers and we are always working to improve the process.

The Service being reviewed was identified through data analysis and you are being sent this notification that a review will be conducted to ensure services are medically reasonable, billed appropriately, and documentation requirements are met. A random sample of **20** claims will be selected. Please see attached list of claims selected for review and a list of additional documentation to be submitted for review.

The targeted Current Procedural Terminology (CPT) and/or Healthcare Common Procedure Coding System (HCPCS) code being reviewed are shown below with descriptor:

- 90834 Psychotherapy, 45 minutes
- 90837 Psychotherapy, 60 minutes

During the review process, First Coast will review the medical records for the claims selected and calculate an error rate based on any dollars denied as errors. Any records not submitted timely as requested will also be calculated in the error rate. Following error rate calculations and summary letter mailing, First Coast will offer to provide one on one education regarding denial reasons and findings.

The medical records must be received by First Coast within 45 days from the date of this additional development request which is **5/10/2021**. Authorization for the release of this information is included in Social Security Act Sections 1815(a), 1833(e) and, 1862 (a)(1)(A). If the requested documentation is not returned within 45 days from the original request, the claim will be denied due to lack of documentation which will contribute to your error rate. It is your responsibility as a provider to provide the requested documentation within the allotted time frame. Additionally, if providers/suppliers do not respond to the ADR request, MACs have the option to refer to the RAC or ZPIC/UPIC as a result.

Post payment reviews will be completed within 60 days of the last date of additional documentation received. If during the review process any additional information is needed a clinical reviewer will contact you with that request. If you have any questions or concerns regarding that request please contact [redacted]

Once the Medical review is complete you will receive a review summary letter with detailed claim decisions and error rate calculations. The review summary letter will contain contact and scheduling information for education.

This letter serves as notification of the review process, initiation of the review and request for medical records. The purpose of the claim review is to ensure documentation supports the reasonable and necessary criteria of the services billed and follows Medicare rules and regulations. In addition, we remind you that our regulation at 42 CFR §424.535 authorizes us to revoke Medicare billing privileges under certain conditions. In particular, we note that per 42 CFR §424.535(a)(8)(ii), CMS has the authority to revoke a currently enrolled provider or supplier's Medicare billing privileges if CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements.

Thank you in advance for your participation with this review. Please contact [redacted] referencing the case number, if you have any questions or wish to provide a contact person or with any questions regarding the information in this letter.

Instructions

The documentation submitted for this review must be a copy of the patient's medical record for each encounter clearly identified for each requested beneficiary and the date of service. Providers/suppliers are responsible for obtaining supporting documentation from third parties (hospitals, nursing homes, suppliers, etc.).

- Refer to the 'Supporting Documentation' attachment for a list of required supporting documentation to be submitted.
- Providers/suppliers must pay the cost of providing this documentation; it cannot be billed to CMS or the MAC program.
- Providers/suppliers are encouraged to respond quickly.
- Please do not include Powers of Attorney, Living Wills, or Correspondence.
- During this review period and at all times, in order to receive payment, providers/suppliers must continue to submit claims for all services performed on a beneficiary.

Submission Methods

Additional information on submission of medical records can be found on the medical documentation webpage at http://medicare.fcso.com/ADR/0410595.asp. Providers can respond to Medical Review additional development requests via the SPOT internet portal as well (https://thespot.fcso.com).

Via postal mail or Encrypted CD/DVD:

1. Include a paper copy of this Post Pay request letter, and the DCN/ICN specific fax cover sheet with your documents.
2. Please do not password protect CDs/DVDs
3. Mail to the following:

Regular Mail

ATTENTION: [redacted]
FIRST COAST SERVICE OPTIONS INC
Medical Review
Post Office Box 3701
Mechanicsburg, Pennsylvania 17055

Overnight Mail

ATTENTION: [redacted]
FIRST COAST SERVICE OPTIONS INC
Medical Review
2020 Technology Park Way, Ste 100
Mechanicsburg, Pennsylvania 17050

Via fax: Enclosed are the DCN/ICN specific cover sheets for each beneficiary included in this review.

1. When submitting medical records via fax or mail, the DCN/ICN specific cover sheet must be placed face up and on top of its corresponding medical documentation.
2. Please ensure that the medical records do not exceed 200 pages when faxing to our office.

Attachments / Supplementary Information

1. Listing of claims requiring medical documentation
2. Supporting Medical Documentation Checklist

Please submit medical records as indicated below:

Include list of staff credentials that rendered services to include names, license numbers and signatures. If the Physicians signature is missing in the documentation, include an attestation signed and dated by the Physician that performed the service. The information should contain sufficient information to identify the beneficiary receiving the services. If the Physicians signature is illegible submit a signature log.

In addition, you are required to submit a copy of any signed Advanced Beneficiary Notices (ABN's/HINN), if applicable. Claims submitted with a GA modifier and an invalid or missing ABN will not transfer liability to the patient. In accordance with CMS Program Integrity Manual Publication 100-08, Chapter 3, Section 3.15 and Publication 100-4, Chapter 30, Section 50.6.3.).

Questions

If you have any questions please contact [redacted] or via postal mail at the following:

First Coast Service Options, Inc.
2020 Technology Park Way, Ste 100
Mechanicsburg, PA 17050

Sincerely,

First Coast MAC Jurisdiction N Medical Review

Enc: SPOT Flyer (Provider Portal)
Additional Development Sample list
Medical Documentation Checklist

This document (letter) contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.

Signature Form

March 25, 2021

Provider: [redacted]
Provider #: [redacted]

Dear [redacted]

In order to help identify the service rendered by you (or your fellow group members), please provide a sample of your signature and initials as they might appear on your progress notes, orders, etc. or please provide a signature log.

Print your full name: _____

SIGNATURE: _____ INITIALS: _____

GROUP MEMBERS: (if applicable)

Sample signatures are also needed for all other group members.

Print the provider's full name: _____

SIGNATURE: _____ INITIALS: _____
Provider #: _____

Print the provider's full name: _____

SIGNATURE: _____ INITIALS: _____
Provider #: _____

Print the provider's full name: _____

SIGNATURE: _____ INITIALS: _____
Provider #: _____

Print the provider's full name: _____

SIGNATURE: _____ INITIALS: _____
Provider #: _____

Please return the completed form with the requested documentation.

Checklist: Psychotherapy Services Documentation

This checklist is intended to provide Healthcare providers with a reference for use when responding to Medical Documentation Requests for Psychotherapy services. Healthcare Providers retain responsibility to submit complete and accurate documentation.

Check Documentation Requirements

1) Documentation is for the correct beneficiary

2) Documentation contains a valid and legible signature

3) Documentation clearly identifies the person performing the service (including title, education background, credentials)

4) Documentation clearly demonstrates session start and stop times and/or total time spent providing psychotherapy services to the beneficiary

5) Documentation demonstrates the type of service being provided (including the therapeutic techniques and approaches including modalities and frequencies of treatment furnished)

6) Documentation supports the medical necessity for psychotherapy treatment (including results of clinical tests, medication prescription and monitoring, and any summary of: diagnosis, functional status, treatment plan, symptoms, prognosis progress, and progress to date)

7) Documentation to support "incident to" guidelines (if applicable), that includes evidence of billing provider supervision and ongoing participation in patient care

8) For services that include an E/M component, the E/M services should be documented.

9) If applicable and required, submitted documentation should include a beneficiary waiver of liability.