ITP and Documentation Guidance: Updated 5/8/20

How do I maintain compliance with ITPs and 30-day direct patient contact requirements?

CMS Interim-Final COVID-19 Rule includes the following bullet in the blanket waivers and burden relief: ***Suspension of in process and future Medicare Fee-For-Service (FFS) medical reviews including prepayment medical reviews conducted by Medicare Administrative Contractors (MACs) under the Targeted Probe and Educate program, and post-payment reviews conducted by the MACs, Supplemental Medical Review Contractor (SMRC) reviews and Recovery Audit Contractor (RAC) for the duration of the PHE.***

AACVPR is hopeful that a "patients over paperwork" philosophy will prevail among the regional MACs (Medicare Administrative Contractors) who oversee cardiac and pulmonary rehabilitation claims submissions and processing, regulations, and payment for Medicare beneficiaries.

AACVPR leadership with program certification and regulatory input offers the following recommendations:

- You may want to consult your compliance department for guidance on documentation procedures through this time.
- Your institution is always able to reach out to your MAC with claims processing questions.
- With the interruption in the delivery of CR and PR services, documentation that the program is on hold until program resumption for coronavirus should be noted on the ITP. Physician signature on this ITP would attest that the patient will resume when the program re-opens. Direct patient contact would obviously also be suspended until resumption of the program.
- As programs begin to re-open, a refreshed ITP can provide an updated assessment and treatment plan going forward.
- Regardless of how you document this time period, the date of onset and date treatment began (both needing to be reported on claims) should remain the same.
- If the CR program exceeds the 36-week window (this should be rare) allowed for completion of the maximum 36 sessions, a modifier KX will be necessary to indicate continued medical necessity in your program's estimation.
    - The regional MACs have deferred to CMS on whether COVID-19 is an acceptable reason for continued medical necessity of the CR/PR service.
    - If your institution requires an ABN be signed by the beneficiary, that patient would be responsible for the cost of any retroactively denied sessions.
    - If your hospital does not require an ABN in this case, your institution would be financially responsible to re-pay any reimbursed, retroactively denied sessions.