How to Avoid Denials for Inpatient Transcatheter Aortic Valve Replacement (TAVR) Services

This article applies to providers who bill inpatient claims for the performance of a Transcatheter Aortic Valve Replacement (TAVR). This procedure is used for the treatment of aortic stenosis when furnished according to the Food and Drug Administration (FDA)-approved indications. Documentation must support that certain conditions are met as outlined in the National Coverage Determination (NCD) for Transcatheter Aortic Valve Replacement (TAVR) (20.32).

The Comprehensive Error Rate Testing (CERT) contractor has issued errors resulting in a denial of inpatient claims due to missing documentation to support the need for the TAVR procedure. The submitted medical records were missing evidence that a cardiac surgeon and an interventional cardiologist experienced in the care and treatment of aortic stenosis have independently examined the patient face-to-face and evaluated the patient's suitability for open aortic valve replacement (AVR) surgery. Both the surgeon and interventional cardiologist must document the rationale for their clinical judgment and that the rationale was available to the heart team. In addition, the heart team's interventional cardiologist(s) and cardiac surgeon(s) must jointly participate in the intra-operative technical aspects of TAVR.

As a reminder, this documentation is just one of the requirements that must be met in order to determine medical necessity for this procedure. The NCD 20.32, Transcatheter Aortic Valve Replacement (TAVR), includes all the covered indications and limitations of coverage for this procedure. Providers should ensure that all documentation to support the medical necessity for this procedure is submitted when requested by CERT and other Medicare contractors.

References: National Coverage Determination (NCD) for Transcatheter Aortic Valve Replacement (TAVR) (20.32).
OPEN: Reason Code 37549

Change Request 12216, Updates to Reason Code Bypass for Editing on Provider Submitted Adjustment Claims Resulting in a Diagnosis Related Group (DRG) Weight Increase, issued May 11, 2021, is to update the reason code 37549 and bypass for editing on provider submitted adjustment claims resulting in a DRG weight increase, but the DRG code on the claim is not changed as a result of the adjustment. CMS instructs MACs to bypass any existing reason code(s) that assign on provider submitted adjustment claims for a DRG weight increase, when the DRG code on the adjustment claim is the same as the DRG code on the original claim. Palmetto GBA has set the processing system to suspend claims with reason code 37549 so they can manually be bypassed. The automated edit updates for reason code 37549, effective October 1, 2021 will be implemented on October 4, 2021. Any provider submitted adjustment claims for a DRG weight increase, when the DRG code on the adjustment claim is the same as the DRG code on the original claim, that have been returned to the provider (RTP) in stat/location TB9997 with reason code 37549; may be returned to the processing system (F9) for manual bypass. Please review this information and share it with your staff.

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