MEDICARE QUARTERLY PROVIDER COMPLIANCE NEWSLETTER

Guidance to Address Billing Errors

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Archive of previous Medicare Quarterly Provider Compliance Newsletters

INTRODUCTION

Learn about avoiding common billing errors and other erroneous activities when dealing with the Medicare Fee-For-Service (FFS) Program. This newsletter includes guidance to help health care professionals address and avoid the top issues of the particular quarter.

There are more than one billion claims processed for the Medicare FFS program each year. Medicare Administrative Contractors (MACs) process these claims, make payments to more than one million health care professionals in accordance with Medicare regulations, and provide education on how to submit accurately coded claims.

Despite actions to prevent improper payments, it is impossible to prevent them all due to the large volume of claims. The Medicare Learning Network's® Medicare Quarterly Provider Compliance Newsletter helps health care professionals to understand the latest findings identified by MACs and other contractors such as Recovery Auditors and the Comprehensive Error Rate Testing (CERT) review contractor, in addition to other governmental organizations such as the Office of the Inspector General (OIG).

The Centers for Medicare & Medicaid Services (CMS) releases the newsletter on a quarterly basis. An archive of previously-issued newsletters, which includes keyword and provider-specific indices, is available on the CMS website.

OFFICE OF INSPECTOR GENERAL (OIG) FINDING: DOUBLE PAYMENT FOR AMBULANCE SERVICES SUBJECT TO SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING (CB) REQUIREMENTS

Provider Types Affected: Ambulance providers and SNFs billing Medicare Administrative Contractors (MACs) for ambulance transportation services provided to SNF Medicare beneficiaries during covered Part A stays and other ambulance suppliers

Background: Under the SNF CB regulations, SNFs are responsible for billing Medicare for most of the services provided to beneficiaries in SNF stays covered under Part A, including services that outside suppliers provide under arrangement (See the Social security Act (the Act) Section 1862(a)(18) and 1842(b)(6)(E)). The outside suppliers must then bill the SNFs for these services.

A 2019 OIG report shows that Medicare made payment on many claims that the OIG determined were Medicare Part B overpayments to ambulance suppliers for transportation services for beneficiaries in Part A SNF stays. The OIG report also notes that beneficiaries incurred unnecessary coinsurance and deductible liabilities related to those incorrect payments. These are overpayments because Medicare made Part B payments to ambulance suppliers for transportation services that were also included in Medicare Part A payments to SNFs as part of CB requirements.

In prior reviews of ambulance transportation payments conducted, OIG found similar results. Medicare added system checks to ensure that ambulance services that are subject to SNF CB rules (but that the ambulance supplier bills separately as a Part B service) are denied when the date of service on the ambulance claim is within the beneficiary's Part A SNF stay. However, these system edits did not go far enough in identifying incorrectly billed ambulance services based on the list of outpatient services (based on HCPCS codes) that suspend or end beneficiaries' SNF resident status. This causes some overpayments to continue.

Medicare overpaid the ambulance suppliers because the Common Working File (CWF) edits didn't prevent or detect Part B overpayments for all transportation subject to SNF CB. Ambulance suppliers did not have the necessary controls to prevent incorrect billing to Medicare Part B.

Finding: Federal regulations state that, with certain exceptions, the SNF benefit includes medically necessary ambulance transportation provided to a SNF resident during a covered Part A stay (42 CFR section 409.27(c)). Therefore, when an ambulance supplier erroneously bills Medicare Part B for ambulance services included in the SNF's Part A CB payment, Medicare pays for the same service twice—once to the SNF and again to the ambulance supplier.

The SNF CB requirement applies only to those services provided to a SNF resident during a covered Part A stay. Therefore, CB excludes ambulance transportation that begins or ends a beneficiary's SNF resident status, or is to receive services that suspend or end their SNF resident status. You should bill these ambulance services to Medicare Part B separately.

SNFs should keep in mind the following about CB as the OIG report points out:

- CB excludes certain outpatient hospital services such as specific emergency or intensive outpatient hospital services that are beyond the scope of a SNF's care. These services temporarily suspend a beneficiary's SNF resident status and are excluded from CB making them eligible for Medicare Part B billing.
- Ambulance transportation for beneficiaries to receive dialysis services is statutorily excluded from consolidated billing and the ambulance supplier may bill the transport to Medicare Part B.
- An ambulance transport from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident and not in a covered Part A stay, including the return trip, is covered under Part B if the ambulance transportation was medically reasonable and necessary and all other coverage requirements are met.

The OIG found that ambulance suppliers didn't confirm their beneficiaries' Part A SNF resident status before billing Medicare or they did not fully understand that some third-party services (for example, ultrasounds, x-rays, and minor surgical procedures) did not suspend resident status and were, therefore, subject to consolidated billing.

CMS is working to update the Medicare claims processing system to detect these claims. They plan to change the CWF edits to prevent Part B overpayments to ambulance suppliers for transportation services provided to beneficiaries in Part A SNF stays. The CWF system edits should prevent or detect overpayments for outside services provided during Part A-covered SNF stays, including outpatient claims and the associated ambulance claims.

CMS is instructing its MACs to recover the overpayments that the OIG identified.

Resources:

You may want to review the following information to help avoid these billing errors:

- OIG Report: Medicare Paid Twice for Ambulance Services Subject to Skilled Nursing Facility Consolidated Billing Requirements: https://oig.hhs.gov/oas/reports/region1/11700506.pdf
- Ambulance Fee Schedule and Medicare Transports Booklet: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Ambulance-Transports-Booklet-ICN903194.pdf
- The Ambulance Fee Schedule website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/index.html
- Sections 1861(e)(1) and 1861(j)(1) of the Social Security Act: https://www.ssa.gov/OP_Home/ssact/title18/1861.htm
- Medicare Benefit Policy Manual, Chapter 10, Section 10.3.3: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c10.pdf
- Medicare Claims Processing Manual, Chapter 15: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c15.pdf
- OIG Report: Payments for Ambulance Transportation Provided to Beneficiaries in Skilled Nursing Stays Covered Under Medicare Part A in Calendar Year 2006: https://oig.hhs.gov/oas/reports/region1/10800505.pdf
- CR595, Ensuring the Denial of Claims for Ambulance Services Rendered to Beneficiaries in Part A Skilled Nursing Facility Stays: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R595OTN.pdf
- MM6700, Ensuring the Denial of Claims for Ambulance Services Rendered to Beneficiaries in Part A Skilled Nursing Facility Stays: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6700.pdf

OIG FINDING: MANY MEDICARE CLAIMS FOR OUTPATIENT PHYSICAL THERAPY SERVICES DID NOT COMPLY WITH MEDICARE BILLING REQUIREMENTS

Provider Types Affected: Physical therapy providers who provide these services to Medicare beneficiaries and bill Medicare Administrative Contractors (MACs) for those services.

Problem Description: The OIG performed a new study on physical therapy claims to see if the claims complied with Medicare's medical necessity, coding, and documentation requirements. Past OIG reviews of individual physical therapy providers identified many claims for physical therapy services that were not reasonable, medically necessary, or properly documented. OIG did this recent review to determine the extent to which these issues are still occurring nationwide.

Medicare Policy: Therapy services are a benefit under Section 1861 (a)(2)(C) of the Social Security Act. Medicare pays for physical therapy services for Medicare beneficiaries only when furnished in accordance with certain conditions.

The goal of physical therapy is to restore maximum functional independence to a patient by providing services that aim to restore function, improve mobility, and relieve pain.

The following conditions apply:

- Services are or were required because the beneficiary needed therapy services (see the Medicare Benefit Policy Manual, Chapter 15, Section 220.1)
- A plan for furnishing such services has been established by a physician or non-physician practitioner (NPP) or by the therapist providing such services and is periodically reviewed by a physician/NPP
- Services are or were furnished while the beneficiary is or was under the care of a physician
  - In certifying an outpatient plan of care for therapy, a physician/NPP is certifying that the above three conditions are met. Medicare requires this certification for coverage and payment of a therapy claim.
- Claims therapists submit for physical therapy services must contain the National Provider (NPI) of the certifying physician

Findings: In the recent OIG report, the OIG determined that payment for physical therapy services did not comply with these Medicare billing requirements. In reviewing the claims and related documentation, the OIG found that the key problems with the failure to comply with Medicare requirements were:

- The services were not reasonable and necessary
- The services were not effective
- The services did not require the skills of a therapist
- The services provided no expectation of significant improvement

OIG found that a significant number of Medicare claims for physical therapy services they reviewed did not comply with Medicare medical necessity, coding, or documentation requirements.

The coding errors included:

- The inclusion of timed units on the claim that did not match then number of units in the treatment notes in the medical records
- The use of incorrect HCPCS codes (for example, billing for therapeutic activities when the medical records indicated that the therapist actually did a reevaluation)

Based on these results, OIG estimated that during the 6-month audit period, Medicare paid $367 million for outpatient physical therapy services that did not comply with Medicare requirements. These overpayments occurred because CMS' controls were not effective in preventing improper payments for outpatient physical therapy services.

Resources:

You may want to review the following information to help avoid errors in billing for outpatient physical therapy services.

- The OIG Report at https://oig.hhs.gov/oas/reports/region5/51400041RIB.pdf
- The Medicare Learning Network booklet, Outpatient Rehabilitation Therapy Services: Complying with Documentation Requirements, at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/OutptRehabTherapy-Booklet-MLN905365.pdf
- MLN Matters Articles:
  - MM9698: "Update to Editing of Therapy Services to Reflect Coding Changes." Applies certain coding edits to new Current Procedural Terminology (CPT) codes used to report physical and occupational therapy evaluations and re-evaluations, effective January 1, 2017.
  - MM10176: "Updated Editing of Always Therapy Services – MCS." Presents guidelines to improve the enforcement of longstanding, existing therapy modifier usage instructions.
- **Internet-Only Manuals:**
  - **Medicare Benefit Policy Manual (Pub. 100-02)**
    - Chapter 15, Section 220: Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance
    - Chapter 15, Section 230: Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology
  - **Medicare Claims Processing Manual (Pub. 100-04)**
    - Chapter 5: Part B Outpatient Rehabilitation and CORF/OPT Services Section 1861 (a)(2)(C) of the Social Security Act at https://www.ssa.gov/OP_Home/ssact/title18/1861.htm