MEDICARE QUARTERLY PROVIDER COMPLIANCE NEWSLETTER

Guidance to Address Billing Errors

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Table of Contents

2 **Introduction**

3 **Comprehensive Error Rate Testing (CERT):** Skilled Nursing Facility (SNF) Certification and Re-certification

6 **Office of Inspector General Finding (OIG):** Studies of Hospital Billings of Use of Modifier 59 on Heart Biopsy Claims and Procedure Coding for Ventilation Support Claims

Archive of previous Medicare Quarterly Provider Compliance Newsletters

INTRODUCTION

This newsletter is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Fee-For-Service (FFS) Program. It 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 newsletter is released on a quarterly basis. An archive of previously-issued newsletters, which includes keyword and provider-specific indices, is available on the Centers for Medicare & Medicaid Services' (CMS) website.

FACILITY (SNF) CERTIFICATION AND RE-CERTIFICATION

Provider Types Affected: Physicians, non-physician practitioners (NPPs), and providers who bill for services related to beneficiaries in Skilled Nursing Facilities (SNFs)

Background: The Medicare SNF benefit pays for certain skilled services provided in various skilled nursing settings, including swing-bed hospitals, nursing homes, and other freestanding facilities; only if the certification and recertification for services meet certain content criteria. There are no specific procedures or required forms for certification and recertification statements. The provider may use any method that allows for verification. The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a special separate form. If the required criteria is contained in other provider records, such as physicians' progress notes, it need not be repeated; it will suffice for the statement to indicate where the information is to be found. For example, if appropriate, the provider could sign and date a statement that indicates all of the required information is included in the medical record and continued post hospital extended care services are medically necessary.

Description: The CERT review contractor reviewed 1,736 SNF claims for the 2016 report period. The improper payment rate for SNF services was 7.8 percent with improper payments projected at $2.8 billion. Insufficient documentation accounted for 75.3 percent of the SNF improper payments. A major source of insufficient documentation errors is due to missing certification and recertification statements in whole or in part (that is, required elements are missing).

Certification Statement Required Criteria

The certification must clearly contain the following information:

1. The individual needs skilled nursing care (furnished directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services
2. Such services are required on a daily basis
3. Such services can only practically be provided in a SNF or swing-bed hospital on an inpatient basis
4. Such services are for an ongoing condition for which the individual received inpatient care in a hospital
5. A dated signature of the certifying physician or NPP

Recertification Statement Required Criteria

The recertification statement(s) must contain the following information:

1. The reasons for the continued need for post-hospital SNF care
2. The estimated time the individual will need to remain in the SNF
3. Plans for home care, if any
4. If the reason for continued need for services is a condition that arose after admission to the SNF (and while the individual was still under treatment for the condition for which the individual received inpatient care in a hospital) this must be indicated
5. A dated signature of the recertifying physician or NPP

Timing of Certifications and Recertifications

1. The certification must be obtained **at the time of admission** or as soon thereafter as is reasonable and practicable.
2. The first recertification is required no later than the **14th day** of post-hospital SNF care.
3. Subsequent re-certifications are required at least **every 30 days** after the first recertification.
4. SNFs are expected to obtain timely certification and recertification statements. However, delayed certifications and re-certifications will be honored where, for example, there has been an isolated oversight or lapse. In addition to complying with the content requirements, delayed certifications and re-certifications **must** include an explanation for the delay and any medical or other evidence which the SNF considers relevant for purposes of explaining the delay.

Finding: Insufficient Documentation Causes Most Improper Payments

Example of Improper Payment Due to Insufficient Documentation-Missing Recertification Element

A SNF submitted a claim for skilled services provided to a beneficiary. The submitted documentation was missing a valid first recertification. The SNF submitted the following documentation:

- Signed recertification form that is missing the estimated length of stay
- Physician’s orders
- Physician’s progress note
- Physical and occupational therapy evaluations and plans of care along with daily treatment notes
- Acute inpatient hospital records

The SNF used a separate form for the recertification statement. While the form had an area for the physician/NPP to document the estimated length of stay, this was left blank and there was no indication of where this information could be located (for example, medical record). This claim was scored as an insufficient documentation error.

Example of Improper Payment Due to Insufficient Documentation-Missing signature

A SNF submitted a claim for skilled services provided to a beneficiary. Submitted documentation included a physician's certification statement with a pre-populated date for the physician signature that was not authenticated. The SNF submitted the following documentation:

- Physician certification statement with a missing signature and pre-populated date
- Physical therapy treatment notes, logs, orders, and evaluation
- Occupational therapy treatment notes, logs, order, and evaluation
- Physician visit notes
- Acute inpatient hospital records
- Nursing notes

An additional request for documentation returned duplicate records. The certification statement criteria was not met and therefore this claim was scored as an insufficient documentation error.

Resources

You may want to review the following information to help avoid errors for billing SNF services:

- 42 CFR 424.11 at https://www.gpo.gov/fdsys/granule/CFR-2010-title42-vol3/CFR-2010-title42-vol3-sec424-11/content-detail.html
- 42 CFR 424.20 at https://www.gpo.gov/fdsys/granule/CFR-2010-title42-vol3/CFR-2010-title42-vol3-sec424-20
- The "Medicare General Information, Eligibility, and Entitlement Manual," Chapter 4, Section 40 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c04.pdf discusses the requirements for certification and recertification by physicians for extended care services.
- The "Medicare Benefit Policy Manual," Chapter 8, Section 40 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf discusses the requirements for physician certification and recertification for extended care services.
- The "Medicare Program Integrity Manual," Chapter 6, Sections 6.1 & 6.3 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf provides information about medical review of SNF claims.
- The CMS CERT Program website is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/index.html
- The CERT Provider website at https://certprovider.admedcorp.com/

OFFICE OF INSPECTOR GENERAL (OIG) FINDINGS: STUDIES OF HOSPITAL BILLINGS OF USE OF MODIFIER 59 ON HEART BIOPSY CLAIMS AND PROCEDURE CODING FOR VENTILATION SUPPORT CLAIMS

Provider Types Affected: Hospitals

Problem Description: In two recent studies, the OIG finds that hospital coding errors for two procedures result in Medicare overpayments. Specifically, in billing for outpatient right heart catheterizations with heart biopsies, hospitals often use modifier -59 inappropriately, which leads to significant overpayments and overpayment recoveries on claims for these services. In the other study, the OIG finds that hospitals are often using incorrect procedure codes when billing for mechanical ventilation. In their study of mechanical ventilation billings, the OIG looked at the relation between Medicare
Severity - Diagnosis Related Groups (MS-DRGs) billed to the procedures coded for those DRGs.

Medicare Policy: Use of Modifier - 59 - Medicare billing policy allows hospitals to include modifier - 59, which indicates that a procedure is separate and distinct from another procedure performed on the same patient on the same day when the procedures performed were not separate and distinct. Some hospitals incorrectly billed outpatient right heart catheterizations (RHCs) that were performed during the same patient encounter as heart biopsies. The OIG analyzed claims to determine if hospitals were correctly using modifier - 59 for RHCs and
heart biopsies.

Incorrect Procedure Coding for Mechanical Ventilation - In a separate study of hospital claims, the OIG looked at the MS-DRG 207 (Respiratory system diagnosis [with] ventilator support 96+ hours) and MS-DRG (Septicimia or severe sepsis [with mechanical ventilation] 96+ hours. In an earlier issue of the Medicare Quarterly Provider Compliance Newsletter (Volume 2, Issue 1), Medicare pointed out that coders were likely looking at the number of days in a stay when coding the procedure code for ventilator support. In that issue, Medicare stressed the importance of using the correct procedure code to show actual hours of ventilator support in order to have the claim paid correctly.

Finding: By appending modifier - 59 to the Healthcare Common Procedure Coding System (HCPCS) code to claims for RHCs and heart biopsies, some hospitals represented that the RHCs were separate and distinct from the heart biopsies; however, the payment for a heart biopsy is generally intended to cover an RHC when the RHC is performed during the same encounter.
In their study of mechanical ventilation claims, the OIG focused on the correlation of the MS-DRG billed with the procedure code that was billed on the same claim. While some hospitals billed MS-DRGs that indicated a stay of 4 days or less, the procedures billed indicated 96 or more consecutive hours of mechanical ventilation was provided to the beneficiary. Such claims represent overpayments.

Examples of Incorrect Use of Modifier - 59

A hospital billed a procedure with modifier - 59 for a beneficiary who received an RHC and a heart biopsy on the same date of service. The medical record documentation did not support the use of the modifier and, as a result, Medicare made an overpayment on the claim. Medicare recovered the overpayment.

Example of Incorrect Procedure Coding on Beneficiary Stay of 4 days or less

The medical records documentation (physician's notes and ventilation records) shows a beneficiary received 68 hours of mechanical ventilation with a stay of 4 days or fewer. However, the claim procedure code showed 96 or more hours of mechanical ventilation were provided. This caused the claim to be grouped to MS-DRG 870, rather than MS-DRG 871. This resulted in a significant overpayment that Medicare recovered from the hospital.

Example of Incorrect Procedure Coding on Beneficiary Stay of 5 days or Longer

The medical records documentation (ventilation records) showed that a beneficiary was in the hospital for 5 days and received a total of 91 hours of ventilation. But, the procedure code on the claim indicated 96 or more consecutive hours of mechanical ventilation was provided. This also resulted in grouping the claim to a MS-DRG that led to a higher and incorrect payment, which Medicare recovered from the hospital.

Guidance for Providers to Avoid Coding Errors

Medicare encourages hospital billing staff to review the Medicare manual sections and other sources noted in the resources below to ensure proper billing of ventilation support services and on the proper use of modifier - 59.

Resources

- The "Medicare Claims Processing Manual," Chapter 3, Inpatient Hospital Billing, Section 10, General Inpatient Requirements at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
- The Medicare Quarterly Provider Compliance Newsletter (Volume 2, Issue 1) at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp_Newsletter_ICN907163.pdf
- The OIG report on Hospitals Nationwide Did Not Comply with Medicare Requirements for Billing Outpatient Right Heart Catheterizations with Heart Biopsies at https://oig.hhs.gov/oas/reports/region1/11300511.pdf
- The OIG report on Medicare Improperly Paid Hospitals for Beneficiaries who had not Received 96 or more Consecutive Hours of Mechanical Ventilation at https://oig.hhs.gov/oas/reports/region9/91402041.pdf