# MEDICARE QUARTERLY PROVIDER COMPLIANCE NEWSLETTER

## Guidance to Address Billing Errors

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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.

## COMPREHENSIVE ERROR RATE TESTING (CERT): BASIC LIFE SUPPORT (BLS) AMBULANCE SERVICES

### Provider Types Affected: Ambulance Suppliers

**Background:** Medicare covers ambulance services, including fixed wing and rotary wing ambulance services, only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. The beneficiary's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Nonemergency Basic Life Support (BLS) ambulance transportation is appropriate if either: the beneficiary is bed-confined, and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. For a beneficiary to be considered bed-confined, the following criteria must be met:

- The beneficiary is unable to get up from bed without assistance.
- The beneficiary is unable to ambulate.
- The beneficiary is unable to sit in a chair or wheelchair.

(See 42 Code of Federal Regulations (CFR) §410.40)

BLS services include the provision of medically necessary supplies and services. BLS ambulance transportation is defined by the State where the transportation is provided.

Medicare requires the signature of the beneficiary, or that of his or her representative, for both the purposes of accepting assignment and submitting a claim to Medicare. If the beneficiary is unable to sign because of a mental or physical condition, Medicare allows certain specified individuals to sign the claim form on their behalf. See 42 CFR §424.36 for the list of authorized individuals. This is known as Assignment of Benefits (AOB). The AOB is signed by the beneficiary or a responsible party. If certain conditions and documentation requirements are met, the ambulance supplier can submit documentation to support that no other qualified person was willing or available to sign the AOB on behalf of the beneficiary.

**Description:** The CERT review contractor reviewed claims for BLS ambulance services for the 2016 report period. The reviewed claims contain the following HCPCS codes for ambulance services:

- A0425 - Ground mileage, per statute mile
- A0428 - Ambulance service, basic life support, non-emergency transport, (BLS)

**Finding:** Insufficient Documentation Causes Most Improper Payments

For the 2016 report period, the improper payment rate for BLS non-emergency transport was 20.0 percent with improper payments projected at $217 million. This was primarily due to insufficient documentation. Insufficient documentation means that something was missing from the medical records. For example, there was:

- No signature from the beneficiary, or other authorized individual, authorizing the supplier of ambulance services to bill Medicare for specified services furnished to the beneficiary
- No supporting documentation for the medical necessity of the level of service provided
- No supporting documentation that the beneficiary could not be safely transported via any other method

## Example of Improper Payments due to Insufficient Documentation – Missing and Illegible Signatures

An ambulance supplier billed for HCPCS A0428 (BLS, non-emergency transport) and mileage from the beneficiary's residence to a dialysis facility. The submitted records were missing a signed copy of the AOB. The ambulance supplier submitted the following:

- An ambulance transport record for the date of service containing illegible signatures by two transport personnel

There was no signature from the beneficiary or a responsible party and no indication that the beneficiary was unable to sign. In response to a request for additional documentation, duplicate transport records and a physician certification for ambulance transport was received. Since the AOB was still missing, the CERT review contractor scored this claim as an insufficient documentation error and the MAC recovered the payment from the supplier.

## Example of Improper Payments due to Insufficient Documentation – Missing Documentation to Support Medical Necessity

An ambulance supplier billed for HCPCS A0428 and mileage. The claim was missing documentation to support the reason(s) that the beneficiary could not have been safely transported via any other method than ambulance. The ambulance supplier submitted the following documentation:

- An AOB signed by the beneficiary
- A signed physician certification statement
- A signed ambulance report for the date of service that stated in part "…patient was transferred from stretcher to wheelchair via a stand and pivot method and taken into her residence…"

An additional request for documentation returned duplicate documentation. The CERT review contractor scored this claim as an insufficient documentation error and the MAC recovered the payment from the supplier.

## Guidance on How Providers Can Avoid These Improper Payments

**Understand the requirements for Medicare coverage of these services and make sure the medical record documentation meets Medicare requirements.**

## Resources

- Find the LCD that applies to your jurisdiction using the Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database/
- "Medicare Ambulance Transports," a booklet designed to educate providers about Medicare ambulance transports, is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Ambulance-Transports-Booklet-ICN903194.pdf
- "Ambulance Fee Schedule," a publication about Medicare payment policy for ambulances, is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AmbulanceFeeSched_508.pdf
- The "Medicare Benefit Policy Manual," Chapter 10, Section 10.2.1 on Necessity for the Service is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c10.pdf
- The "Medicare Claims Processing Manual," Chapter 15, Section 20.5 on Documentation Requirements, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c15.pdf
- 42 CFR 424.36 is available at https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol3/pdf/CFR-2011-title42-vol3-sec424-36.pdf
- 42 CFR 410.40 is available at https://www.gpo.gov/fdsys/pkg/CFR-2014-title42-vol2/pdf/CFR-2014-title42-vol2-sec410-40.pdf
- The CERT Program website is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/index.html

## RECOVERY AUDITOR FINDING: "T" STATUS INDICATOR CODES

### Provider Types Affected: Physicians and Non-Physician Practitioners (NPPs)

**Problem Description:** HCPCS/CPT Codes with a Medicare Physician Fee Schedule Data Base (MPFSDB) Status Indicator "T" are only paid if there are no other services payable under the physician fee schedule billed on the same date of service, for the same beneficiary and by the same provider.

**Medicare Policy:** There are Relative Value Units (RVUs) and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule, are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made.

**Finding:** The Recovery Auditor determined that a HCPCS/CPT Code with a MPFSDB Status Indicator "T" was billed on the same day as another payable service under the physician fee schedule resulting in improper payments due to an unbundled service included in a claim for another billed service.

Medicare recovered the improper payment amounts that were determined to be in error.

### Guidance for Providers to Avoid Coding Errors

Medicare encourages physicians, NPPs, and their billing staff to review the Medicare manual sections noted in the resources below to ensure proper billing of "T" Status Indicator Codes.

### Resources

- The "Medicare Claims Processing Manual," Chapter 23, Fee Schedule Administration and Coding Requirements, Section 30.2.2, MPFSDB Status Indicators is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf

## RECOVERY AUDITOR FINDING: LABORATORY SERVICES SUBJECT TO END STAGE RENAL DISEASE (ESRD) CONSOLIDATED BILLING

### Provider Types Affected: Clinical Laboratories and ESRD Facilities

**Problem Description:** The ESRD Prospective Payment System (PPS) includes consolidated billing for limited Part B services included in the ESRD facility bundled payment. Certain laboratory services and limited drugs and supplies are subject to the Part B consolidated billing and are no longer separately payable by Medicare when provided for ESRD beneficiaries by providers other than the renal dialysis facility.

**Medicare Policy:** Effective January 1, 2011, Section 153b of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires that all ESRD-related laboratory tests must be billed by the renal

dialysis facility whether provided directly or under arrangements with an independent laboratory. When laboratory services are billed by providers other than the ESRD facility and the laboratory service furnished is designated as a service that is included in the ESRD PPS (ESRD-related), Medicare will reject or deny the claim. In the event that an ESRD-related laboratory service was furnished to an ESRD beneficiary for reasons other than for the treatment of ESRD, the provider may submit a claim for separate payment using modifier AY.

**Finding:** The Recovery Auditor determined the claims on the audit indicate that a laboratory service was billed for an ESRD beneficiary who received services from a dialysis center on the same date of service. As a result, the laboratory service(s) should not be separately paid. Medicare recovered the identified overpayments from the providers.

### Guidance for Providers to Avoid Coding Errors

Medicare encourages ESRD facilities and laboratories to review the documents noted in the resources below to ensure proper billing of laboratory services for ESRD beneficiaries.

### Resources

- The “Medicare Claims Processing Manual,” Chapter 8, Lab Services, Section 60.1 is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c08.pdf
- MLN Matters article MM7064 provides additional information on the MIPPA changes and is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm7064.pdf

## RECOVERY AUDITOR FINDING: TECHNICAL COMPONENT OF DIAGNOSTIC PROCEDURES DURING INPATIENT PROFESSIONAL SERVICES

### Provider Types Affected: Part A and B providers who perform inpatient professional services that include diagnostic procedures and their Technical Component (TC).

**Problem Description:** When billed on the same date of service as an inpatient hospital claim, the TC of diagnostics is not payable to the Part B provider. The TC is performed by the facility while a patient is in a covered Part A Inpatient Stay. This relates to the CPT Code Range from 10000-99999 (excluding CPT Codes 70000-89999), with Professional Component (PC)/TC Indicators of 1 and 3.

**Finding:** The Recovery Auditor identified claims with improper payments. Based on the ”Medicare Claims Processing Manual,” Chapter 23, Addendum-MPFSDB File Layouts, the TC of diagnostic procedures with PC/TC indicators of 1 and 3, when billed by a Part B provider on the same date of service as an inpatient hospital claim, is not payable to the Part B provider. The claims examined by the audit indicate that the Part B provider billed for the TC portion of diagnostic procedures during an inpatient hospital stay.

## Guidance on How Providers Can Avoid These Errors

Medicare reminds providers that the TC of a diagnostic procedure is only payable to the inpatient hospital.

Medicare notes the following guidance about the use of PC/TC Indicators 1 and 3.

- **Indicator 1 - Diagnostic tests or radiology services:** This indicator identifies codes that describe diagnostic tests, for example, pulmonary function tests, or therapeutic radiology procedures, such as radiation therapy. These codes generally have both a professional and technical component. Modifiers 26 and TC can be used with these codes. The total Relative Value Units (RVUs) for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier equals the sum of RVUs for both the PC and TC.
- **Indicator 3 - TC only codes:** This indicator identifies stand-alone codes that describe the TC (staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the PC of the diagnostic tests only. An example of a TC code is 93005 (Electrocardiogram, tracing only, without interpretation and report). It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes. The total RVUs for TC-only codes include values for practice expense and malpractice expense only.

The PC of a provider-based physician's services is defined as activities that are directly related to the medical care of the individual patient, such as diagnosing or treating the patient's condition.

## Resources

- The "Medicare Claims Processing Manual," Chapter 23, Addendum-MPFSDB File Layouts, 2001-2011 File Layout is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf
- The "Medicare Claims Processing Manual," Chapter 23, Section 30, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf
- Section 1869(b)(1)(G) of the Social Security Act is available at https://www.ssa.gov/OP_Home/ssact/title18/1869.htm
- 42 CFR 405.980 is available at https://www.gpo.gov/fdsys/search/pagedetails.action?granuleId=CFR-2007-title42-vol2-sec405-980&packageId=CFR-2007-title42-vol2

## RECOVERY AUDIT FINDING: CODING VALIDATION FOR SKILLED NURSING FACILITY (SNF) CLAIMS

### Provider Types Affected: SNFs

**Problem Description:** The Recovery Auditor reviewed claims submitted by SNFs to determine the extent to which the Minimum Data Set (MDS) is accurate and supported by the resident's medical records. Upon receipt of this requested documentation, the entire benefit period was reviewed to determine the appropriate level of care—not including the determination of medical necessity. The improper payment involved with this review is overpayment.

Two error codes relate to this study and the reviewed claims:

- **1600:** No documentation was received, or no documentation related to the claim line under review was received from the provider, after full process was pursued and exhausted, and there is no evidence to support another error code.
- **4100:** Include only those lines of service where the reviewer concluded, based on actual evidence in the records, that the services the provider billed and the MAC paid were either not performed, or products were not provided. **Note:** Do not include duplicate billing or where insufficient documentation raises the doubt that the provider rendered the service, but where no actual proof is in evidence. There must be confirmation from the provider that the service was not provided.

**Findings:** The review for this subject focused on three states (Alabama, Georgia, and Tennessee), and featured a population of 4,276 claims with more than $39 million worth of potential overpayments.

In identifying SNF claims as potential overpayments, the following two criteria were used:

1. Identify SNF claims billed with dates of service of October 1, 2010, or greater, billed using Type of Bill (TOB) 21X (excluding 210), and
2. Select claims with Health Insurance Prospective Payment System (HIPPS) codes containing a Therapy Resource Utilization Group (RUG) (RU, RV, RH, RM, RL in the first two positions.)

### Guidance on How Providers Can Avoid These Problems

To verify that the Medicare bill accurately reflects the assessment information, three data items derived from the MDS assessment must be included on the Medicare claim:

- **Assessment Reference Date (ARD)**
  - The ARD must be reported on the Medicare claim. If an MDS assessment was not completed, the ARD is not used and the claim must be billed at the default rate. CMS has developed mechanisms to link the assessment and billing records.

- **The RUG IV Group**
  - The RUG group is calculated from the MDS assessment data. The software used to encode and transmit the MDS assessment data calculates the appropriate RUG group.
- **Health Insurance PPS (HIPPS) Codes**
  - Each Medicare PPS assessment is used to support Medicare Part A payment for a maximum number of days. The HIPPS code must be entered on each claim, and must accurately reflect which assessment is being used to bill the RUG IV group for Medicare reimbursement.

## Resources

- The Office of Inspector General (OIG) Report, OEI-02-09-00200, is available at https://oig.hhs.gov/oei/reports/oei-02-09-00200.asp
- MDS 3.0 RAI, Chapter 6, Section 6.4, of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, is available at https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf#page=633
- The "Medicare Benefit Policy Manual," Chapter 8, Section 30.2, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf