DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

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Medicare Learning Network®

Official Information Health Care Professionals Can Trust

Medicare Quarterly Provider Compliance Newsletter

Guidance to Address Billing Errors

Updated Provider Index Now Available!
See the Introduction section for more details

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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.

Provider Types Affected legend:

Hospitals

Providers Part B

Physicians

Durable Medical Equipment Suppliers

Professional Physician / Non-Physician

Clinical Diagnostic Laboratories

Recovery Auditor Finding: Acute Hospital Readmissions without Condition Code B4 or 42

H

Provider Types Affected: **Hospitals**

Problem Description

An improper payment occurs when two separate acute hospital claims are paid for a Medicare beneficiary who is discharged and re-admitted on the same day and for the same Diagnosis Related Group (DRG) and there is no B4 or 42 Condition Code (CC) on the second claim. These condition codes would indicate the following:

- B4 - Admission Unrelated to Discharge - Admission unrelated to discharge on same day.
- 42 - Continued care not related to inpatient admission - Continuing care plan is not related to the condition or diagnosis for which the individual received inpatient hospital services.

Description of the Issue

According to the **"Medicare Claims Processing Manual," Pub. 100-04, Chapter 3, Section 40.2.5** on the Centers for Medicare & Medicaid Services (CMS) website: when a beneficiary is discharged/transferred from an acute care Prospective Payment System (PPS) hospital, and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals should adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim. However, a beneficiary is discharged/transferred from an acute care PPS hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms unrelated to, and/or not for evaluation and management of, the prior stay's medical condition, hospitals shall place condition code (CC) B4 on the claim that contains an admission date equal to the prior admissions discharge date.

Medicare Learning Network® MLN Matters® Article Number **MM3389** conveys this same message.

Thus, it is very important for the hospital to determine the cause of the same day, same provider readmission and code the claim correctly.

What You Should Know

- Be aware that upon request of the Quality Improvement Organization (QIO), hospitals will be required to submit medical records pertaining to the readmission.

Helpful Links

The **"Medicare Claims Processing Manual," Pub. 100-04, Chapter 3, Section 40.2.5** is available on the CMS website.

Audit Findings

The Recovery Auditors are finding claims for readmissions occurring without an approriate CC and, when such findings occur, those claims are deemed overpayments and the overpayments are recovered from the providers.

Guidance on how providers can avoid these billing errors

Hospitals are encouraged to review the manual descriptions and MM3389 as referenced above. If the claims cannot be billed with the CC B4 or CC 42, then the claims should be combined and billed as one hospital stay.

Resources

- ✓ The **"Medicare Claims Processing Manual," Pub. 100-04, Chapter 3, Section 40.2.5** is available on the CMS website.
- ✓ The Medicare Learning Network® MLN Matters® Article Number **MM3389** is also available on the CMS website.

Recovery Auditor Finding: Exact Duplicate Professional Claims

P PPB

Provider Types Affected: **Physicians and Other Providers Submitting Part B Professional Claims**

Problem Description

The Recovery Auditors conducted an automated review to identify duplicate professional services billed on separate claims that may include but are not limited to the following criteria:

- Same Health Insurance Claim (HIC) Number (HICN);
- Same provider number;
- Same from date of service;
- Same through date of service;
- Same type of service;
- Same place of service;
- Same billed amount; and
- Same procedure code.

Providers need to be aware that an overpayment may result when a provider bills and is paid for services that have been previously processed and paid.

Description of the Issue

The **"Medicare Claims Processing Manual," Chapter 1, Section 120.2**, Detection of Duplicate Claims, is available on the CMS website. That manual section includes criteria to identify duplicate claims. This would include same HIC Number, Provider number, Date of Service, Type of service, Procedure codes, Place of service, and Billed amount.

Claims or claim lines that have been determined to be exact duplicates of another claim or claim line are denied. However, such denials may be appealed. Providers should inquire as to the status of their claim if they do not receive payment within a certain timeframe, rather than submitting a duplicate claim.

There are instances where claims appear as duplicates, but are, in fact, not duplicates. For such claims, the **"Medicare Claims Processing Manual," Chapter. 4, Section 20.6**, Use of Modifiers, is available on the CMS website. That section contains several subsections describing the use of modifiers and how they can be applied to identify procedures that are not duplicate services.

What You Should Know

- Providers need to be aware that an overpayment may result when a provider bills and is paid for services that have been previously processed and paid.

Helpful Links

The **"Medicare Claims Processing Manual," Chapter 1, Section 120.2**, Detection of Duplicate Claims, is available on the CMS website.

Audit Findings

The Recovery Auditors have identified numerous potential duplicate claims from Part B providers and these claims are sent to the Medicare Administratice Contractors (MACs) for appropriate action, including recovery of overpayments.

Guidance on how providers can avoid these billing errors

Physicians are encouraged to review the manual descriptions noted in the resources below to ensure correct use of modifiers to identify procedures on claims that are not duplicate services.

Resources

- ✓ The **"Medicare Claims Processing Manual," Chapter. 4, Section 20.6**, Use of Modifiers, is available on the CMS website.
- ✓ The "**Medicare Claims Processing Manual," Chapter 1, Section 120.2**, Detection of Duplicate Claims, is available on the CMS website.

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Recovery Auditor Finding: Multiple Surgeries

Provider Types Affected: **Physicians and Non-Physician Practitioners**

Problem Description

The Recovery Auditor conducted an automated review to identify surgical claims that contain Current Procedural Terminology (CPT®) codes with a "Multiple Procedure" Indicator Value of "2" or "3," that were incorrectly reported by the same physician, on the same beneficiary on the same day, whether on different claims, different lines, or with a number greater than 1 in the units column for each code reported on the claim form and which resulted in an overpayment.

Description of the Issue

The **"Medicare Claims Processing Manual," Chapter 12, Section 40.6**, which is available on the CMS website, states that multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same beneficiary at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same beneficiary on the same day.

The following procedures apply when billing for multiple surgeries by the same physician on the same day.

- Report the more major surgical procedure **without** the multiple procedures modifier "-51."
- Report additional surgical procedures performed by the surgeon on the same day **with** modifier "-51."

Medicare's Multiple Surgery Pricing Logic

Medicare pays for multiple surgeries by ranking from the highest physician fee schedule amount to the lowest physician fee schedule amount. When the same physician performs more than one surgical service at the same session, the allowed amount is based on 100% of the highest physician

What You Should Know

- Medicare prices bilateral procedures (Modifier 50) as one allowed amount when ranking the services.

Helpful Links

The **"Medicare Claims Processing Manual," Chapter 12, Section 40.6**, which is available on the CMS website.

fee schedule amount. The allowed amount for the subsequent surgical codes is based on 50% of the physician fee schedule amount for each of the other codes. Medicare requires no modifier for multiple surgical procedures. Medicare prices bilateral procedures (Modifier 50) as one allowed amount when ranking the services. For endoscopic procedures, Medicare applies the endoscopic pricing rules prior to the multiple surgery rules. Multiple surgery pricing logic also applies to assistant-at-surgery.

The **"Medicare Claims Processing Manual," Chapter 23**, Addendum, which is available on the CMS website, describes Multiple Procedures (Modifier 51). The Indicator Value indicates which payment adjustment rule for multiple procedures applies to the service as follows:

- "2" = Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report).

  Base the payment on the lower of:

  a) The actual charge, or

  b) The fee schedule amount reduced by the appropriate percentage.

- "3" = Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (that is, another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in field 31G.

Apply the multiple endoscopy rules to a family before ranking the family with other endoscopies performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure).

If an endoscopic procedure is reported with only its base procedure, Medicare does not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy.

Audit Findings

Improper payments were identified by the Recovery Auditors and were referred for overpayment collection from the providers.

Guidance on how providers can avoid these billing errors

Physicians are encouraged to review the manual descriptions and the local coverage decisions for their region noted above to ensure correct use of indicators for multiple procedures on claims. You may access these documents from the resources section below.

Resources

- ✓ The **"Medicare Claims Processing Manual," Chapter 12, Section 40.6**, which is available on the CMS website, states that multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same beneficiary at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same beneficiary on the same day.
- ✓ The **"Medicare Claims Processing Manual," Chapter 23**, Addendum, which is available on the CMS website, describes Multiple Procedures (Modifier 51).

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Comprehensive Error Rate Testing (CERT): Referring Providers/Third Party Documentation

Provider Types Affected: **Hospitals**

Problem Description

The Comprehensive Error Rate Testing (CERT) program calculates the Medicare Fee for Service (FFS) improper payment rates for many major claim types.

After the CERT program identifies a claim as part of the sample, it requests by letter, the associated medical records and other pertinent documentation from the provider or supplier who submitted the claim. For some claim types (for example, DMEPOS, clinical diagnostic laboratory services), in addition to the initial request for documentation sent to the billing provider and supplier, the referring provider who ordered the item or service may also receive a documentation request. This is done because sometimes the referring provider maintains the documentation to support the medical necessity of the services billed. However, it is the responsibility of the billing provider to supply the requested documentation regardless of the place of service.

Section1833 (e) of the Social Security Act requires that Medicare payments are made to providers only where the provider has furnished the necessary information or documentation that permits Medicare to determine the necessity of the services and to price the services appropriately. CERT must check for documentation to support the performance of services and the provision of DMEPOS to ensure that all Medicare requirements are met.

What You Should Know

- The CERT Documentation Contractor call center operates between the hours of 8:00 AM to 6:00 PM Eastern Standard Time, and their phone number is (301) 957-2380 or toll free 1-888-779-7477.

Helpful Links

Sample CERT documentation request letters are available for review on the **CERT Provider Website**.

CERT Findings

Insufficient Documentation Causes Most Improper Payments

The most common cause of improper payments found by the CERT program is insufficient documentation. This is often due to failure of the referring physicians or non-physician practitioners to provide adequate documentation of:

- Their orders or their intention to order services or DMEPOS items, or
- The clinical information that supports the medical necessity of the services or DMEPOS items.

When CERT samples claims from DMEPOS suppliers, clinical diagnostic laboratories or suppliers of ambulances services, the providers receive specific instructions that include these statements:

- You must provide medical record documentation to support claims for Medicare services upon request.
- It is your responsibility to obtain, as necessary, additional supporting documentation from a third party (hospital, nursing home, etc.).
- Please provide the requested documentation as soon as possible.
- If you fail to produce the requested information by this date, the CERT program will assume that the services on the claim were not rendered and your local Medicare contractor will initiate claims adjustments and/or overpayment recoupment actions for these undocumented services.

Sample CERT documentation request letters are available for review on the **CERT Provider Website**. If physicians or non-physician practitioners receive such requests, they can send the required documentation directly to the CERT Documentation Contractor using the bar coded cover sheet and instructions sent with the request.

Examples of Improper Payments due to Insufficient Documentation from Third Parties

Insufficient Documentation – Missing Order or Intent to Order

A mobile imaging supplier billed for a radiologic examination, chest single view - frontal, for a date of service in January 2014. The submitted documentation was missing the treating/referring physician's order or clinical documentation to support the plan or intent to order the billed x-ray. The lack of medical records from the treating/referring physician also meant that there was no medical necessity established for the chest x-ray.

The initially submitted documentation included a signed and dated interpretation/report for the portable chest x-ray. There was also a chest x-ray request form from the mobile imaging supplier with technologist’s initials circled and a Physician's Interim/Telephone Orders on the date of service. The CERT reviewer requested additional documentation and received another copy of the request form.

This claim was scored as an insufficient documentation error and the Medicare Administrative Contractor (MAC) recouped payment for the portable chest x-ray from the mobile imaging supplier.

Note that this insufficient documentation error could have been corrected if the treating/referring physician had submitted progress notes (or visit notes) including intent to order the chest x-ray and support for the medical necessity of the chest x-ray.

Insufficient Documentation – Missing Order or Intent to Order

A laboratory billed for an unlisted immunology procedure for a date of service in February 2015. The submitted documentation was missing a valid physician order or documented intent to perform the unlisted immunology procedure.

The initially submitted documentation included the report of the test results and a laboratory requisition for the testing with a physician's verbal order. The verbal order was not co-signed. The CERT reviewer requested additional documentation and received duplicates of the documentation. There was insufficient documentation to meet indications and documentation per Medicare requirements.

This claim was scored as an insufficient documentation error and the MAC recouped payment for the test from the medical laboratory.

Note that this insufficient documentation error could have been corrected if the treating/referring physician had submitted progress notes (or visit notes) including intent to order the test and support for the medical necessity of the test.

Resources

You can find more information on the CERT program at:

- The **CERT Provider Website**; and
- The **CMS CERT Website**.

Comprehensive Error Rate Testing (CERT): Lower Limb Prosthetics

H P DMES

Provider Types Affected: **Hospitals, Physicians, and Durable Medical Equipment Suppliers**

Problem Description

The Comprehensive Error Rate Testing (CERT) program samples and reviews claims for Lower Limb Prosthetics (LLPs) during each reporting period. A lower limb prosthesis is covered when the beneficiary will reach or maintain a defined functional state within a reasonable period of time and is motivated to ambulate. The medical record must document the beneficiary's current functional capabilities and their expected functional potential, including an explanation for the difference, if that is the case. Some amputees such as bilateral amputees may not be strictly bound by functional level classifications.

A determination of the medical necessity for certain components/additions to the prosthesis is based on the beneficiary's potential functional abilities. Potential functional ability is based on the reasonable expectations of the prosthetist and treating physician, considering factors including, but not limited to:

1. The beneficiary's past history (including prior prosthetic use if applicable);
2. The beneficiary's current condition including the status of the residual limb and the nature of other medical problems; and
3. The beneficiary's desire to ambulate.

Clinical assessments of beneficiary rehabilitation potential must be based on the following classification levels:

Level 0: Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.

Level 1: Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.

Level 2: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.

What You Should Know

- A lower limb prosthesis is covered when the beneficiary will reach or maintain a defined functional state within a reasonable period of time and is motivated to ambulate.

Helpful Links

LCD for Lower Limb Prostheses (L11442) available on the CMS website.

Level 3: Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.

Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

CERT Findings

Insufficient Documentation Causes Most of the Improper Payments

The vast majority of the improper payments are due to insufficient documentation. Insufficient documentation means that something is missing from the medical records. For example, the medical record was missing one or more of the following:

- The order for the prosthesis/prosthesis replacement
- The correct date of service
- A physician's signature
- A signature log or attestation for an illegible signature on a specific date of service
- Physician's documentation to support the functional level
- Documentation of the reason for the replacement. This may be documented by the ordering physician either on the order or in the medical record and must fall under one of the following:
  - A change in the physiological condition of the beneficiary resulting in the need for a replacement. Examples include, but are not limited to, changes in beneficiary weight, changes in the residual limb, beneficiary functional need changes.
  - An irreparable change in the condition of the device, or in a part of the device resulting in the need for a replacement.
  - The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of replacement device, or, as the case may be, of the part being replaced.

Examples of Improper Payments due to Insufficient Documentation for Lower Limb Prosthetics

Insufficient Documentation – Missing Functional Level

A prosthetist billed for new prosthetic components, date of service January 2014. The submitted medical records were missing clinical documentation from the physician to support the expected functional level indicated by Modifier K2 (that is, functional level two) for the beneficiary. The submitted documentation included a supplier generated order (signed and dated in November 2013), and the prosthetist's notes for the 3 month period from November to January. The notes support that the beneficiary is a new amputee

and include the initial evaluation, measurements, and final fitting upon delivery. A physician's authenticated progress note dated in December 2013 support that the beneficiary had a recent Left Above Knee Amputation (AKA).

Despite support for the medical necessity of the procedure, claim payment also requires documentation supporting the expected functional level of the beneficiary. This claim was scored as an insufficient documentation error.

Insufficient Documentation – Missing the Reason for Replacement

A prosthetist billed for a replacement Healthcare Common Procedural Coding System (HCPCS) L5679 (addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism, 2 units) and for HCPCS L8430 (prosthesis socks, multi-ply, above knee, 6 units) for a date of service in April 2014.

The submitted documentation was missing the physician's documentation of the reason that the beneficiary needed a replacement component for the Right lower limb prosthesis. The submitted documentation included a physician's order prior to the date of service dated in April 2014; Certified Prosthetist Orthotist (CPO) notes dated during the two months preceding the billed date of service; a Certificate of Medical Necessity dated the day of the physician's order; and a proof of delivery.

The CERT reviewer requested additional documentation but received none. This claim was scored as an insufficient documentation error because the submitted documentation did not support medical necessity per Local Coverage Determination (LCD) and Medicare requirements.

Resources

- ✓ **Local Coverage Determinations (LCDs) and Policy Articles for Lower Limb Prosthetics-Policy Article-Effective January 2014 (A25528)**, which is available on the CMS website;
- ✓ **LCD for Lower Limb Prostheses (L11442)**, which is available on the CMS website;
- ✓ Social Security Act (SSA), **Section 1834**(h)(G)(i), Section 1834(h)(F)(II)(iii), and Section 1834(h)(F)(III);.
- ✓ **42 Code of Federal Regulations (CFR) 424.5(a)(6)** (sufficient information);
- ✓ The **"Medicare Program Integrity Manual," Chapter 5,** Sections 5.7 (documentation in the beneficiary's medical record), 5.8 (supplier documentation), and 5.9 (evidence of medical necessity); and
- ✓ Office of Inspector General (OIG) Reports **"Questionable Billing by Suppliers of Lower Limb Prostheses,"** and **"National Government Services, Inc., Paid Unallowable Lower Limb Prosthetics Claims."**

Comprehensive Error Rate Testing (CERT): Frequency Limitations on Services

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Provider Types Affected: **Clinical Diagnostic Laboratories, Hospitals, and Physicians**

Problem Description

CERT has found some improper payments due to screening services that exceed Medicare's frequency limitations. Such limitations do not apply to individuals with risk factors, or distinct signs or symptoms. Examples of frequency limitations are:

- Payment may be made for a one-time ultrasound screening for Abdominal Aortic Aneurysm for beneficiaries who meet the specific criteria.
- A single, one-time Hepatitis C screening test is covered for adults who are not considered high risk, but who were born from 1945 through 1965.

Example of an Improper Payment due to Frequency Limitations

Screening Pap Smears

A 74-year-old beneficiary went to her primary care physician for a gynecologic check-up in July 2013. She had no complaints and had a negative review of systems. Her blood pressure was well controlled on medication. She had no medical history or other findings indicating the presence of cervical or vaginal cancer or other abnormalities during any of the preceding 3 years. Specifically, this beneficiary had no high risk factors for cervical or vaginal cancer. The physician performed and documented a normal examination

CERT randomly selected the laboratory claim for Healthcare Common Procedure Coding System (HCPCS) 88175 (a Pap smear) from the July 2013 gynecologic check-up. The submitted documentation included a lab requisition for cervical cytopathology testing and test results, but was missing the order for the testing. The office visit note did not document the intent to order the test or support the need or medical necessity for cytopathology screening in this low-risk beneficiary.

Also included with the submitted documentation were previous cytopathology results for the years 2012 and 2011, which were both reported as "Within normal limits." In addition, a review of Medicare's paid claims history showed a prior billing for HCPCS 88175 in 2012. Per

What You Should Know

- A single, one-time Hepatitis C screening test is covered for adults who are not considered high risk, but who were born from 1945 through 1965 (National Coverage Determination 210.13).

Helpful Links

The **"Medicare Benefit Policy Manual,"** Chapter 15, Section 80.1 Clinical Lab Services, and Section 80.6.1 Requirements for Ordering and Following Orders for Diagnostic Tests, which is available on the CMS website.

Medicare guidelines, "payment may be made for a screening Pap smear after 23 months have passed after the end of the month of the last covered smear" for women at normal risk. Therefore, this testing exceeded the frequency limit for Pap smears.

It is the responsibility of the billing provider to supply the requested documentation regardless of the place of service. This claim was scored as an insufficient documentation error due to a lack of support for the medical necessity of Pap smear testing in July 2013.

Informational Note about Screening Pelvic Examinations (this is not the same screening service as a pap smear)

Medicare covers a screening pelvic examination (including a clinical breast examination) once every two years for an asymptomatic woman only if she has not had a screening pelvic examination paid for by Medicare during the preceding 23 months following the month in which the last Medicare-covered screening pelvic examination was performed. The HCPCS code is G0101 (cervical or vaginal cancer screening, pelvic and clinical breast examination). Medicare payment may be made for a screening pelvic examination performed more frequently than once every 23 months if the test is performed by a physician or other practitioner and there is evidence that the woman is at high risk (on the basis of her medical history or other findings) of developing cervical cancer or vaginal cancer.

Please note that the initial publication of this newsletter incorrectly stated a screening pelvic examination was covered every three years. Medicare actually covers this examination every two years and the preceding paragraph shows the correct information.

Resources

- ✓ The **"Medicare Benefit Policy Manual," Chapter 15,** Section 80.1 Clinical Lab Services, and Section 80.6.1 Requirements for Ordering and Following Orders for Diagnostic Tests, which is available on the CMS website;
- ✓ The **"Medicare Claims Processing Manual," Chapter 18**, Preventive and Screening Services and Ch. 18, Section 30 Screening Pap Smears, which is available on the CMS website;
- ✓ The publication **"Your Guide to Medicare's Preventive Services"**; and
- ✓ **Preventive Services Interactive Tool**, which is also on the CMS website.

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