



MEDICARE QUARTERLY PROVIDER COMPLIANCE NEWSLETTER

Guidance to Address Billing Errors

Volume 8, Issue 2

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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 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): ADVANCE CARE PLANNING

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

Background: Advance Care Planning (ACP) is a face-to-face service that includes counseling and discussion of an advance directive. [MLN Matters Article MM9271](#) describes an advance directive as a “document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time.”

Medicare pays for ACP as either:

- A separate Part B service when it is medically necessary
- A voluntary optional element of a beneficiary's Annual Wellness Visit (AWV)

When voluntary ACP is performed as an optional element of the AWV, there is an explanation and discussion of advance directives such as standard forms, with or without completing such forms. This includes discussing the care the patient would want to receive if he/she becomes unable to speak for his/herself. It must be conducted by the physician or other qualified health care professional; face-to-face with the patient, family member(s), and/or surrogate.

Description of Special Study: The CERT review contractor conducted a special study of claims with lines for ACP billed with Current Procedural Terminology (CPT) code 99497 (ACP by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate) submitted from April through June 2016. MLN Matters Article MM9271 states that practitioners would report CPT code 99497 (plus add-on code 99498 for each additional 30 minutes, if applicable) for the ACP services.

When CERT reviews a claim, all lines submitted on the claim undergo complex medical review to determine whether the claim was paid properly under Medicare coverage, coding, and billing rules.

Finding: Insufficient Documentation Causes Most Improper Payments

Most improper payments in this special study were due to insufficient documentation. Insufficient documentation means something was missing from the submitted medical records to support payment for the services billed.

Many ACP special study claims with insufficient documentation lacked:

- Clinical documentation to support that a face-to-face service, discussing ACP, was performed, and/or
- Clinical documentation of the time spent discussing the ACP

Example of Improper Payments due to Insufficient Documentation – Missing clinical documentation of the time spent discussing the ACP

A physician billed for HCPCS 99497 and in response to the CERT review contractor's request for documentation, the physician submitted the following:

- Complete annual wellness visit note for the date of service that documents end of life planning discussion with the beneficiary with no indication of time element
- Other office visit notes
- Diagnostic reports

The office note submitted was insufficient to determine the amount of time spent on the explanation and discussion of advance directives with the beneficiary and/or family during the office visit. Without documentation of the time spent, the submitted records were insufficient to meet Medicare requirements. The CERT review contractor scored this claim as an insufficient documentation error and the MAC recovered the payment from the billing provider.

Example of Improper Payments due to Insufficient Documentation – Missing clinical documentation of the face-to-face ACP service and missing clinical documentation of the time spent discussing the ACP

A physician billed for HCPCS 99497 and in response to the CERT review contractor's request for documentation, the physician submitted the following:

- A progress note from the date of service that documented beneficiary with chest pain and acute coronary syndrome after a four day hospitalization with diagnosis of polymyalgia rheumatic and a history of pernicious anemia
- A procedure note for vitamin B12 injection
- A hospital discharge note
- A hospital admission note
- An unsigned cardiolyte stress test
- Emergency room medical records
- An order invoice from the date of service showing an order for ACP first 30 minutes

Additional requests to the provider for documentation to support the HCPCS code billed returned no documentation. The provider failed to submit medical record documentation to support the performance of and the time spent on the ACP. The CERT review contractor scored this claim as an insufficient documentation error and the MAC recovered the payment from the billing provider.

Example of Improper Payments due to Insufficient Documentation – Missing clinical documentation of the time spent discussing the ACP

A physician billed for HCPCS 99497 and in response to the CERT review contractor's request for documentation, the physician submitted the following:

- An annual wellness visit questionnaire dated prior to the date of service
- An office visit note from the date of service that documented "...does not have a health care power of attorney or living will, these were discussed in paper work given today."

The office note submitted was insufficient to determine the amount of time spent on the explanation and discussion of advance directives with the beneficiary and/or family during the office visit. Without documentation of the time spent, the submitted records were insufficient to meet Medicare requirements. The CERT review contractor scored this claim as an insufficient documentation error and the MAC recovered the payment from the billing provider.

Resources:

You may want to review the following information to help avoid insufficient documentation errors for ACP services:

- Section 1833 (e) of the Social Security Act is available at https://www.ssa.gov/OP_Home/ssact/title18/1833.htm.
- The regulation at 42 CFR 424.5 (a)(6), which is available at <https://www.gpo.gov/fdsys/pkg/CFR-1999-title42-vol2/pdf/CFR-1999-title42-vol2-part424-subpartB.pdf>.

- The “Medicare Claims Processing Manual,” Chapter 18, Section 140.8 on Advance Care Planning (ACP) as an Optional Element of an Annual Wellness Visit (AWV), which is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf>.
- The “Medicare Benefit Policy Manual,” Chapter 15, Section 280.5.1 on Advance Care Planning (ACP) Furnished as an Optional Element with an Annual Wellness Visit (AWV) Upon Agreement with the Patient, which is available at <http://www.cms.gov/manuals/downloads/bp102c15.PDF>.
- CPT 2016
- The CERT provider website is available at <https://certprovider.admedcorp.com>.
- 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>.
- MLN Matters Article MM9271 is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm9271.pdf>.

REMINDER: PROPER USE OF MODIFIER 59

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

Background:

The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when two Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes should not be reported together either in all situations or in most situations. However, for PTP edits that have a Correct Coding Modifier Indicator (CCMI) of “1,” the codes may be reported together only in defined circumstances which are identified on the claim by the use of specific NCCI-associated modifiers. (Refer to the “National Correct Coding Initiative Policy Manual for Medicare Services,” Chapter 1, for general information about the NCCI program, PTP edits, CCMI, and NCCI-associated modifiers. This manual is available in the download section at <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>).

As stated in [MLN Matters Article SE1418](#), the “CPT Manual” defines modifier 59 as follows:

“Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.”

Modifier 59 and other NCCI-associated modifiers should NOT be used to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used.

Change Request (CR) 8863 announced the creation of four new modifiers that allow for more specificity in describing the distinct services. The four new modifiers and their descriptions are as follows:

- XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter,
- XS Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/ Structure,
- XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner, and
- XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service.

While the new X- modifiers have been effective since January 1, 2015, providers are still permitted to use modifier 59. However, remember that modifier 59 is **NOT to be used** to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used.

Finding:

There are still many instances where modifier 59 is used inappropriately.

Resources:

You may wish to review the following resources in order to avoid problems in using modifier 59:

- MLN Matters Article SE1418, available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se1418.pdf>, provides details and examples on the proper use of modifier 59.
- MLN Matters Article MM8863, available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8863.pdf>, provides information on the four X- modifiers.
- MLN Matters Article SE1503, available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se1503.pdf>, provides information on the continued use of modifier 59 in view of the new X- modifiers.
- The CPT Manual includes the definition of Modifier 59, as well as CPT codes used with Modifier 59. The manual is available at <http://www.ama-assn.org/ama>.

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