

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



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# 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

The Medicare Fee-For-Service (FFS) program contains a number of payment systems, with a network of contractors that processes more than one billion claims each year, submitted by more than one million providers, including hospitals, physicians, Skilled Nursing Facilities, clinical laboratories, ambulance companies, and suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). These contractors, called “Medicare claims processing contractors,” process claims, make payments to health care providers in accordance with Medicare regulations, and educate providers on how to submit accurately coded claims that meet Medicare guidelines. Despite actions to prevent improper payments, such as pre-payment system edits and limited medical record reviews by the claims processing contractors, it is impossible to prevent all improper payments due to the large volume of claims.

The Centers for Medicare & Medicaid Services (CMS) issues the “Medicare Quarterly Provider Compliance Newsletter,” a Medicare Learning Network® (MLN) educational product, to help providers understand the major findings identified by Medicare Administrative Contractors (MACs), Recovery Auditors, Program Safeguard Contractors, Zone Program Integrity Contractors, the Comprehensive Error Rate Testing (CERT) review contractor and other governmental organizations, such as the Office of Inspector General. This is the fourth issue in the third year of the newsletter.

This issue includes 11 findings identified by Recovery Auditors and three items related to CERT findings. This educational tool is designed to help FFS providers, suppliers, and their billing staffs understand their claims submission problems and how to avoid certain billing errors and other improper activities when dealing with the Medicare FFS program. An archive of previously-issued newsletters is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MedQtrlyCompNL\\_Archive.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MedQtrlyCompNL_Archive.pdf) on the CMS website.

This newsletter describes the problems, the issues that may occur as a result, the steps CMS has taken to make providers aware of the problems, and guidance on what providers need to do to avoid the issues. In addition, the newsletter refers providers to other documents for more detailed information wherever that may exist.

The findings addressed in this newsletter are listed in the Table of Contents and can be navigated to directly by “left-clicking” on the particular issue in the Table of Contents. A searchable index of keywords and phrases contained in both current and previous newsletters is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MedQtrlyCompNL\\_Index.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MedQtrlyCompNL_Index.pdf) on the CMS website. In addition, a newly-enhanced index is now available that provides a listing of all Recovery Auditor and CERT Review Contractor findings from previous newsletters. The index is customized by specific provider types to help providers quickly find and learn about common billing and claim review issues that impact them directly. For more information, visit the newsletter archive at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyCompNL\\_Archive.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyCompNL_Archive.pdf) on the CMS website.

## Comprehensive Error Rate Testing (CERT): Home Health Certification

**Provider Types Affected:** Home Health Providers, Physicians, and Non-Physician Practitioners

**Background:** The CERT program's reviews of Home Health Prospective Payment System (HH PPS) claims have identified many improper payments.

### **Requirements for Home Health Prospective Payment System:**

As a condition for payment, the Affordable Care Act mandates that, prior to certifying a beneficiary's eligibility for the home health benefit, the certifying physician must document that he or she or an allowed non-physician practitioner (NPP) had a face-to-face encounter with the beneficiary. The regulation governing the face-to-face encounter requires the documentation to include "...an explanation of why the clinical findings of such encounter support that the patient is homebound and in need of either intermittent skilled nursing services or therapy services..."<sup>1</sup>

### **Improper Payments by Type of Error:**

The majority of HH PPS improper payments are due to insufficient documentation errors. Insufficient documentation errors occur when the medical documentation submitted is inadequate to support payment for the services billed or when a specific documentation element that is required as a condition of payment is missing. Examples of specific documentation elements include the physician signature on an order, or a form that is required to be completed in its entirety.

Most insufficient documentation errors for HH PPS result from claims in which the clinical findings from the face-to-face encounter, details about these findings supporting the beneficiary's homebound status, or the need for skilled services are missing or inadequately documented. Some of the records reviewed contain very little clinical information beyond simple lists of diagnoses, recent injuries, or procedures. Often, the need for skilled nursing is justified with only a diagnosis, such as chronic obstructive pulmonary disease, osteoarthritis, or fracture of the humerus. In some records, the beneficiary's homebound status is documented only by a notation such as "gait abnormality" or "taxing effort."

As described in the regulation (i.e., 42 CFR 424.22(a)(1)(v)), such information is not sufficient; the face-to-face encounter documentation must explain why the findings from the encounter support the medical necessity of the services ordered and the beneficiary's homebound status. Also, the "Medicare Benefit Policy Manual" states that the documentation must include a brief narrative that "describes how the patient's clinical condition as seen during that encounter supports the patient's homebound status and need for skilled services."<sup>2</sup>

### **Examples of HH PPS Improper Payments:**

1. This example shows that the physician provided only a list of diagnoses.

Mrs. Jones had a face-to-face encounter with a physician for the purpose of certifying the beneficiary's eligibility for home health benefit. The face-to-face encounter record is quoted below:

*"The encounter with the patient was in whole, or in part, for the following medical conditions, which is the primary reason for home health care: osteoarthritis, dementia, idiopathic scoliosis, osteoporosis, gait abnormality."*

No other clinical information was submitted. In order for the home health benefit to be covered by Medicare, documentation of the beneficiary's face-to-face encounter must include an explanation of why the clinical findings of such encounter support that the patient is homebound and in need of either intermittent skilled nursing services or therapy services. The claim was scored as an improper payment due to an insufficient documentation error because the certifying provider did not explain why the findings from the encounter supported the medical necessity of the services ordered or the beneficiary's homebound status. The use of general phrases such as "unable to leave home" and "leaving the home requires a considerable and taxing effort" are not sufficient to meet this requirement.

<sup>1</sup>42 CFR 424.22(a)(1)(v) <sup>2</sup>CMS Pub. 100-2, Ch.7, Section 30.5.1.1

2. This example shows that the documentation lacked details to support the beneficiary's homebound status.

Mr. Smith's physician completed a face-to-face encounter form as part of the certification that Mr. Smith required home health benefits. The sentence below was the only mention of Mr. Smith's homebound status:

*"There exists a normal inability of patient to leave home; leaving the home requires a considerable and taxing effort."*

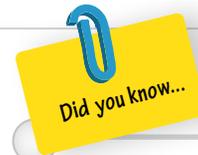
No other clinical information was submitted. In order for the home health benefit to be covered by Medicare, documentation of the beneficiary's face-to-face encounter must include an explanation of why the clinical findings of such encounter support that the patient is homebound. The claim was scored as an improper payment due to an insufficient documentation error because the certifying individual did not explain why the findings from the encounter supported the beneficiary's homebound status. The use of general phrases such as "unable to leave home" and "leaving the home requires a considerable and taxing effort" are not sufficient to meet this requirement.

#### Resources for Providers:

- Providers who would like additional information about Medicare's HH PPS can refer to MLN Matters® Article SE1219, "A Physician's Guide to Medicare's Home Health Certification, including the Face-to-Face Encounter," available at <http://www.cms.gov/Outreach-and-Education/>

[Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1219.pdf](#) on the Centers for Medicare & Medicaid Services (CMS) website.

- 42 Code of Federal Regulations (CFR) 424.22, "Requirements for home health services" is available at <http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol3/pdf/CFR-2011-title42-vol3-sec424-22.pdf> on the Internet.
- The "Medicare Benefit Policy Manual," Chapter 7, Section 30.5.1.1 is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf> on the CMS website.



- Are you billing correctly for ordered/referred services? Will you be impacted when CMS turns on the edits for these services? See MLN Matters® articles [#SE1221](#), [#SE1011](#), and the MLN fact sheets "[Medicare Enrollment Guidelines for Ordering/Referring Providers](#)" and "[The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement](#)" to learn what you need to do.
- The Centers for Medicare & Medicaid Services has posted an updated [Medicare FFS Version 5010 835 Health Care Claim Payment/Advice Companion Guide](#) to the [Medicare FFS Companion Guides](#) web page.



## Comprehensive Error Rate Testing (CERT): Glucose Monitoring Supplies

**Provider Types Affected:** Durable Medical Equipment (DME) Suppliers

**Background:** The CERT program's reviews of claims for glucose monitoring supplies have consistently yielded high improper payment rates. Claims for glucose monitoring supplies selected by CERT included the following items:

- Current Procedural Terminology (CPT) code A4253 (Blood Glucose/Reagent Strips);
- CPT A4256 (Normal, low and high calibrator solution/chips);
- CPT A4258 (Spring-powered device for lancet, each); and
- CPT code A4259 (Lancets, per box of 100).

**Requirements for Glucose Monitoring Supplies:** As a condition of Medicare coverage, the diabetic beneficiary's medical record must contain sufficient documentation of the beneficiary's medical condition to support the need for the type and quantity of items ordered and for the frequency of use or replacement. Documentation must include such elements as a physician's order for the glucose monitoring supplies, evaluations demonstrating physician oversight of the beneficiary, and the need for glucose monitoring supplies.

For Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provided on a recurring basis (i.e., refills), billing must be based on prospective, not retrospective use. In addition to information that justifies the initial provision of the supplies, there must be information in the beneficiary's medical record to support that the item remains reasonable and

necessary. Information used to justify continued medical need must be timely for the date of service under review. Suppliers must not deliver refills without a refill request from a beneficiary. Items delivered without a valid, documented refill request will be denied as not reasonable and necessary.

Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers must stay attuned to changed or atypical utilization patterns on the part of their clients. Suppliers must verify with the ordering physicians that any changed or atypical utilization is warranted. Regardless of utilization, a supplier must not dispense more than a three month quantity at a time.

**Improper Payments by Type of Error:** Most of the improper payments for glucose monitoring supplies are due to insufficient documentation to support the glucose monitoring supplies billed. Critical documentation that is often missing from the submitted records included:

- The order for the glucose monitoring supplies, stating the number of times per day the beneficiary is to test his or her glucose level; and/or
- Physician's notes showing the beneficiary's diabetic condition and the need for glucose monitoring at the frequency billed; and/or

- Physician's notes showing periodic reviews of the glucose monitoring orders within Medicare's designated timeframes.

Other improper payments for glucose monitoring supplies are attributed to medical necessity errors. For example, improper payments occur because the beneficiary exceeds allowable utilization limits by concurrently receiving glucose monitoring supplies from multiple suppliers.

Here is an example of an improper claim: A claim for blood glucose test strips was submitted for a beneficiary who did not require insulin. The quantity of blood glucose test strips ordered exceeded the utilization amounts covered by Medicare for non-insulin dependent diabetic beneficiaries. Clinical documentation was missing that supported the medical need for this quantity of blood glucose test strips. In addition, no documentation was submitted supporting that the treating physician had seen the beneficiary and evaluated diabetic control within the six months prior



to ordering the blood glucose test strips. The claim was scored as an improper payment due to an “insufficient documentation error.”

**Resources for Providers:**

Providers who would like additional information on avoiding improper payments for blood glucose self-testing equipment and supplies for Medicare beneficiaries can refer to these resources:

- MLN Matters® Article SE1008 “Medicare Coverage of Blood Glucose Monitors and Testing Supplies,” available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1008.pdf> on the CMS website; and
- Local Medicare Coverage Determinations, available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx> on the CMS website.

**Did you know...**

The Medicare Learning Network® (MLN) recently issued a series of MLN Matters® Special Edition articles to provide education on OIG findings related to Recovery Audit issues. The articles include information about these issues and guidance health care professionals can use to avoid them in the future. For a complete listing of these articles and other articles designed to help health care professionals understand common billing errors and avoid improper payments, go to [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProvCmpl\\_Articles.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProvCmpl_Articles.pdf) on the CMS website.



## Comprehensive Error Rate Testing (CERT): Inpatient Psychiatric Facility Prospective Payment System (PPS)

**Provider Types Affected:** Hospitals

**Background:** The CERT program's reviews of claims for inpatient psychiatric hospitalizations in hospitals subject to the Inpatient Psychiatric Facility Prospective Payment System (PPS) have identified many improper payments. Claims for inpatient psychiatric hospitalizations selected by CERT included claims in both inpatient psychiatric facilities and exempt psychiatric units of acute care hospitals.

**Requirements for Inpatient Psychiatric Facility:** As a condition of Medicare coverage, the beneficiary's medical record must contain physician certification and recertification statements. In addition to the standard requirements relating to the medical necessity of an inpatient admission, in these institutions the admitting physician is required to include a signed statement in the beneficiary's medical record attesting that the admission is appropriate.

The admission certification is required at the time of admission or as soon thereafter as is reasonable and practicable. It must state that inpatient psychiatric services were required:

- For treatment that could reasonably be expected to improve the patient's condition; or
- For diagnostic study.

If the beneficiary continues to require active inpatient psychiatric treatment, a physician must then recertify as of the 12th day of hospitalization

that the services were and continue to be required for treatment that could reasonably be expected to improve the patient's condition, or for diagnostic study, and that the patient continues to need daily active treatment furnished directly by, or requiring the supervision of, inpatient psychiatric facility personnel.

Subsequent recertifications are required at intervals to be determined by the institution's Utilization Review committee, but no less frequently than every thirty days.

**Improper Payments by Type of Error:** The majority of Inpatient Psychiatric Facility PPS improper payments are due to insufficient documentation errors. Insufficient documentation errors occur when the medical documentation submitted is inadequate to support payment for the services billed or when a specific documentation element that is required as a condition of payment is missing. Examples of specific documentation elements include the physician signature on an order, or a form that is required to be completed in its entirety. Most insufficient documentation errors for Inpatient Psychiatric Facility PPS result from claims in which the required physician certification and recertification statements are missing. Other improper payments included such errors as lack of medical necessity. Medical necessity errors occur when adequate documentation is received to make an informed decision that the services billed are not medically necessary based upon Medicare coverage policies.

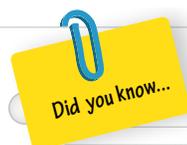
### Examples of Inpatient Psychiatric Facility PPS Improper Payments

1. **Insufficient Documentation Error:** A beneficiary presented to the emergency department with the assistance of a mental health caseworker who had found him at home in bed. The beneficiary stated that he was depressed and had not taken his medications for about a week. He had a history of recurrent exacerbations of a major depressive disorder, complicated by progressive Parkinson's disease, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD). On presentation in the emergency department, his Global Assessment of Functioning Scale (GAF) score deteriorated considerably compared to his baseline GAF score. He was admitted as an inpatient to a Medicare certified inpatient psychiatric unit for reestablishment of his psychiatric medications and evaluation. In order to be covered by Medicare, the beneficiary's inpatient psychiatric medical record must contain a physician certification. The claim was scored as an improper payment due to an insufficient documentation error because the physician certification was missing from the submitted documentation.
2. **Medically Unnecessary Service or Treatment Error:** A beneficiary was transferred from another hospital after treatment for

alcohol withdrawal. On arrival, the beneficiary had evidence of mild withdrawal symptoms, and was stable. He had alcohol dependence treatment in the past. Inpatient treatment was not medically necessary for this episode. This claim was scored as a medically unnecessary service error because this beneficiary's treatment could have been provided as outpatient services.

#### Resources for Providers:

- "Inpatient Psychiatric Facility PPS," available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/index.html> on the CMS website;
- 42 CFR 424.14, "Requirements for inpatient services of inpatient psychiatric facilities" (71 FR 37504, June 30, 2006) available at [http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr424\\_main\\_02.tpl](http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr424_main_02.tpl) on the Internet;
- "Medicare General Information, Eligibility, and Entitlement Manual," Chapter 4, Section 10.9, "Physician Certification and Recertification of Services," available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c04.pdf> on the CMS website;
- "Medicare Benefit Policy Manual," Chapter 2, Section 30.2.1, "Inpatient Psychiatric Hospital Services," available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c02.pdf> on the CMS website; and
- Local Medicare Coverage Determinations, available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx> on the CMS website.



- The Medicare Learning Network® (MLN) has released a new package of products designed to educate physicians and other Medicare and Medicaid providers about medical identity theft and strategies for addressing it. These products include a web-based training course that is approved for Continuing Education (CE) and Continuing Medical Education (CME) credit. For more information, visit the MLN Provider Compliance web page at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html> and click on the 'Medicaid Program Integrity: Safeguarding Your Medical Identity Educational Products' link under 'Downloads' at the bottom of the page.
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## Recovery Audit Finding: Infusion Pump Denied/Accessories & Drug Codes Should Be Denied

**Provider Types Affected:** Durable Medical Equipment (DME)Suppliers

**Problem Description:** Medicare policy requires that when the infusion pump claim is denied, then the infusion accessories and infusion drugs are also denied. The Recovery Auditors conducted an automated review of claims for infusion pumps, accessories and drugs. Of the claims reviewed, a significant number of claims had overpayments for billing of accessories and drugs associated with a denied infusion pump.

**Here are two examples of excess billings:**

**Example 1:** A 73 year-old male was denied an E0784 (Insulin external ambulatory infusion pump) on April 5, 2007. The same patient was then allowed 13 units of A4221 (supplies for maintenance of drug infusion catheter) and 30 units of K0552 (supplies for external drug infusion pump, syringe type cartridge) on April 5, 2007. No paid claims exist for the E0784 within the same rental month as the A4221 and K0552. Per Local Coverage Determination (LCD) 11570, supplies are covered if the related pump is covered. Therefore, the 13 units of A4221 and the 30 units of K0552 are overpaid for April 5, 2007.

**Example 2:** A 63 year-old female was denied an E0784 (Insulin external ambulatory infusion pump) on September 7, 2007. The same patient was then allowed 3 units of A4221 (supplies for maintenance of drug infusion catheter) on September 30, 2007. No paid claims exist for the E0784 within the same rental month as the

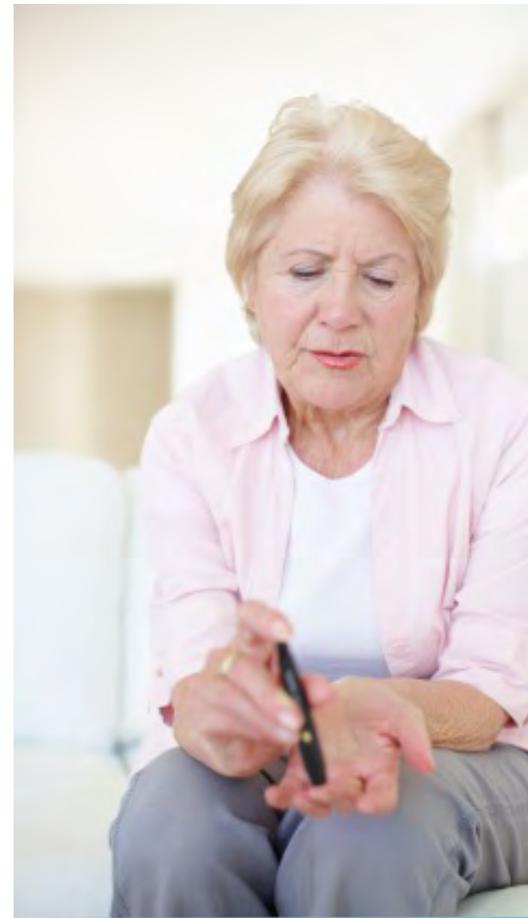
A4221. Per LCD 11570, supplies are covered if the related pump is covered. Therefore, the 3 units of A4221 are overpaid for September 30, 2007.

### Guidance on How Providers Can Avoid These Problems:

DME suppliers who submit claims for infusions pumps need to know the billing requirements for infusion accessories and drugs. You are encouraged to review the following documents in the Local Coverage Determinations section of the Medicare Coverage Database:

- ✓ “External Infusion Pumps” addresses coverage indications, limitations, and medical necessity, coding and general information. Please find this document, updated 2/17/2013, posted by your DME MAC (L11555, L2745, L5044 or L11570), available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx> on the CMS website.
- ✓ “External Infusion Pumps,” policy article, effective 1/1/ 2013, discusses non-medical necessity coverage and payment rules and coding guidelines. Please find this document, updated 3/15/2013, posted by your DME MAC (A20210, A47226, A19713, or A19834), available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx> on the CMS website.

- ✓ The “Medicare National Coverage Determinations Manual,” Chapter 1, Part 4, Coverage Determinations, Section 280.14, Infusion Pumps discusses coverage of external infusion pumps, and is available at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1\\_Part4.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf) on the CMS website.



## Recovery Audit Finding: Overutilization of Nebulizer Medications

**Provider Types Affected:** DME Suppliers

**Problem Description:** A table of the maximum units per month for inhalation drugs to meet medical necessity is published in the Local Coverage Determination (LCD) for Nebulizers. Claims billed for units that exceed the allowable amounts will be considered an overpayment.

The Recovery Auditors conducted an automated review of claims for inhalation drugs and found a significant number of claims had overpayments for billing of inhalation drugs in excess of the amounts covered under medical necessity.

The Recovery Auditors conducted the review of claims for inhalation drugs with the following J codes:

- J2545 PENTAMIDINE ISETHIONATE;
- J7605 ARFORMOTEROL;
- J7606 FORMOTEROL FUMARATE;
- J7608 ACETYLCYSTEINE;
- J7611 ALBUTEROL;
- J7612 LEVALBUTEROL;
- J7620 ALBUTEROL;
- J7626 BUDESONIDE;
- J7631 CROMOLYN SODIUM;
- J7639 DORNASE ALFA;
- J7644 IPRATROPIUM BROMIDE; and
- J7669 METAPROTERENOL SULFATE.

**Here are two examples of excess billings:**

**Example 1:** A 66 year-old male was dispensed 360 units of J7620 (Albuterol/Ipratropium Combination: Albuterol, up to 2.5 mg., and

Ipratropium Bromide, up to 0.5 mg., administered through DME) on May 21, 2012. The same patient was then dispensed another 360 units of J7620 on June 11, 2012 and another 360 units of J7620 on July 2, 2012. In total, the patient received 1080 units of J7620 in three months. Per the LCD, patients are allowed 186 units of J7620 per one month refill period. Based on the number of units dispensed in June and July 2012, the excess units dispensed in May were not for use in the following two months. Therefore, 174 units of J7620 dispensed May 21, 2012 are overpaid. At the time of this service the policy in effect allowed for delivery of refills no sooner than 10 days prior to the end of usage for the current product.

**Example 2:** A 60 year-old female was dispensed 1200 units of J7611 (Albuterol, inhalation solution, administered through DME, concentrated form, 1 mg.) on February 14, 2012. The same patient was dispensed 1200 units of J7611 on March 19, 2012 and an additional 1200 units on April 20, 2012. In total, the patient received 3600 units of J7611 in three months. Per the LCD, patients are allowed 465 units of J7611 per one month refill period. Based on the number of units dispensed in March and April 2012, the excess units dispensed in February were not for use in the following two months. Therefore, 735 units of J7611 dispensed February 14, 2012 are overpaid. At the time of this service, the policy in effect allowed for delivery of refills no sooner than 10 days prior to the end of usage for the current product.

### Guidance for Providers to Avoid Coding Errors:

DME suppliers who submit claims for inhalation drugs need to know the maximum units per month that may be billed to meet medical necessity guidelines. You are encouraged to review the following documents in the LCD section of the Medicare Coverage Database:

- ✓ “Nebulizers,” addresses coverage indications, limitations, and medical necessity, accessories, inhalation drugs and solutions, including **a table representing the maximum milligrams/month of inhalation drugs that are reasonable and necessary for each nebulizer drug**, and refill requirements. Please find this document, updated 3/15/2013, posted by your DME MAC (L5007, L27226, L11499, or L11488), available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx> on the CMS website. Once at that site, enter the key word “nebulizers” where requested and select the appropriate choice for Geographic Area/Region to view the applicable LCD.
- ✓ “Nebulizers” - Policy Article - Effective April 2013. Search for the article posted by your DME MAC (A24623, A47233, A24944, A24944, or 24942), available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx> on the CMS website. This document addresses coding information and general information about

documentation requirements, prescription requirements and medical record information, in addition to coverage indications, limitations, and medical necessity, accessories, inhalation drugs and solutions, including a table representing the maximum milligrams/month of inhalation drugs that are reasonable and necessary for each nebulizer drug, and refill requirements.

- ✓ The “Medicare National Coverage Determinations Manual,” Chapter 1, Part 4, Coverage Determinations, Section 280.1 has a Durable Medical Equipment Reference List, and is available at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1\\_Part4.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf) on the CMS website.

Did you know...

The Medicare Learning Network® (MLN) Product Ordering System was recently upgraded to add new enhancements. You can now view an image of the product and access its downloadable version, if available, before placing your order. To access a new or revised product available for order in hard copy format, go to [MLN Products](#) and click on “MLN Product Ordering Page” under “Related Links” at the bottom of the web page.



## Recovery Audit Finding: Post-Acute Transfer - Underpayments

**Provider Types Affected:** Inpatient Hospital – Acute Care

**Problem Description:** The Recovery Auditors conducted an automated review of inpatient claims with qualifying Diagnosis-Related Groups (DRGs) that were identified with discharge disposition to an acute care inpatient facility (02), skilled nursing facility (03), home health (06), inpatient rehab facility (62), long-term care facility (63), or psychiatric facility (65). These inpatient claims fall under the Post Acute Care Transfer (PACT) policy and are reimbursed on per diem rate, up to full Medicare Severity Diagnosis Related Group (MS-DRG) code reimbursement. However, there is no identified claim submission from the supposed receiving facility.

**Medicare Policy:** Medicare allows its contractors to reopen claims for good cause when evidence from data analysis identifies errors or patterns of overutilization on the part of a provider or supplier. This causes the contractor to believe its initial determinations for the claims of the provider or supplier were incorrect as noted in the “Medicare Claims Processing Manual,” Chapter 3, Inpatient Hospital Billing, Sections 20.1.2.4, Transfers, and 40.2.4, Inpatient Prospective Payment Systems (IPPS) Transfers Between Hospitals, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf> on the CMS website.

The Code of Federal Regulations (CFR) at 42 CFR Sections 405.980(b) and (c), and 405.986, states that a contractor may reopen an initial determination made on a claim between 1 year and 4 years from the date of the initial determination when good cause exists.

- This instruction offers clarification as to what constitutes new and material evidence, as it relates to good cause for reopening the claims. Justification for reopening these claims was due to improper payments found in the results of the data analysis.
- Inpatient claims were identified with discharge disposition to an acute care inpatient facility (02), skilled nursing facility (03), home health (06), Inpatient rehab facility (62), long-term care facility (63), or psychiatric facility (65).
- These inpatient claims fall under the Post Acute Care Transfer policy and are reimbursed on per diem rate, up to full MS-DRG reimbursement.
- However, there is no identified claim submission from a receiving facility.

Therefore, the inpatient claims will be adjusted to receive the full MS-DRG reimbursement. These are underpayments in favor of the provider.

### Guidance on How Providers Can Avoid These Problems:

- ✓ Providers and their coders should review the “Medicare Claims Processing Manual,” Chapter 3, Inpatient Hospital Billing, Sections 20.1.2.4, Transfers, and 40.2.4, Inpatient Prospective Payment Systems (IPPS) Transfers Between Hospitals, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf> on the CMS website.
- ✓ To avoid payment errors, please remind staff to code claims as transfers only if the beneficiary is discharged to another facility.
- ✓ Ensure that the discharge disposition to an acute care inpatient facility (02), skilled nursing facility (03), home health (06), inpatient rehab facility (62), long-term care facility (63), or psychiatric facility (65) is correct, so that you will receive correct reimbursement. These discharge dispositions are reimbursed on per diem rate, up to full MS-DRG reimbursement.
- ✓ Review the full text of the Code of Federal Register, 42 CFR 412.4, Discharges and Transfers, available at <http://www.gpo.gov/fdsys/pkg/CFR-2004-title42-vol2/pdf/CFR-2004-title42-vol2-sec412-4.pdf>, which generally provides the following:
  - Payment for discharges. The hospital discharging an inpatient is paid in full, . . .
  - Payment for transfers. Generally, a hospital that transfers an inpatient . . . is paid a graduated per diem rate for each day of the patient’s stay in that hospital, not to exceed the amount that would have been paid . . . if the patient had been discharged to another setting. Payment is graduated by paying twice the per diem amount for the first day of the stay and the per diem amount for each subsequent day, up to the full DRG payment. (Edited for ease of reading. See full text at the Web address cited above.)

## Recovery Audit Finding: Co-Surgery Not Billed with Modifier 62

**Provider Types Affected:** Physicians

**Problem Description:** The Recovery Auditors have identified significant payment errors because of failure to appropriately apply the co-surgeon modifier, used when two or more surgeons of different specialties contribute to one operative session and each separately submit claims to Medicare. They found many instances of improper payments when two surgeons performed surgery on the same patient, where one surgeon added the co-surgeon modifier 62 and the other did not. When two different providers bill the same CPT code, same patient and same date of service and one of the providers bills with modifier 62, the other provider must also bill with modifier 62. Improper payments exist when two surgeons perform surgery on the same patient; one surgeon added the co-surgeon modifier 62 and the other did not. Note, however, that modifier 62 may only be used when the co-surgeons are of different specialties and are working together on the same procedure.

**Medicare Policy:** The “Medicare Claims Processing Manual,” Chapter 12, Section 40.8, Claims for Co-surgeons and Team Surgeons, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf> on the Centers for Medicare & Medicaid Services (CMS) website, provides the following guidance:

Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient’s condition. In these cases, the additional physicians are not acting as assistants-at-surgery. If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier 62. Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, i.e., heart transplant.

The following billing procedures apply when billing for a surgical procedure or procedures that required the use of two surgeons or a team of surgeons:

- **Modifier 62:** If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier “-62.” Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, i.e., heart transplant or bilateral knee replacements. Documentation of the medical necessity for two surgeons is required for certain services identified in the Medicare Fee Schedule Data Base (MFSDB).

- **Modifier 66:** If a team of surgeons (more than 2 surgeons of different specialties) is required to perform a specific procedure, each surgeon bills for the procedure with a modifier “-66.” Field 25 of the MFSDB identifies certain services submitted with a “-66” modifier which must be sufficiently documented to establish that a team was medically necessary. All claims for team surgeons must contain sufficient information to allow pricing “by report.”

If surgeons of different specialties are each performing a different procedure (with different CPT codes), neither co-surgery nor multiple surgery rules apply (even if the procedures are performed through the same incision). If one of the surgeons performs multiple procedures, the multiple procedure rules apply to that surgeon’s services.

For co-surgeons (modifier 62), the fee schedule amount applicable to the payment for each co-surgeon is 62.5 percent of the global surgery fee schedule amount. Team surgery (modifier 66) is paid for on a “By Report” basis.

### Case Examples from the Review

**EXAMPLE 1:** A provider bills for CPT Code 61548, Hypophysectomy or excision of pituitary tumor, and billed with modifier 62, for a patient on date of service March 8, 2012. A different provider bills for the same service for the same patient on the same date of service because he/

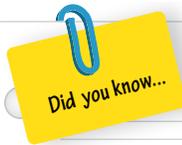
she was the co-surgeon, yet did not bill with the modifier 62. The second surgeon was overpaid for failing to properly apply modifier 62.

**EXAMPLE 2:** A provider bills for CPT Code 49652, Laparoscopy, Surgical repair, ventral, umbilical, spigelian or epigastric hernia, and billed with modifier 62, for a patient on July 2, 2011. A different provider bills for the same service for the same patient on the same date of service because he/she was the co-surgeon, yet did not bill with modifier 62. The second surgeon was overpaid for failing to properly apply modifier 62.

In both of these examples, providers should append the appropriate modifier to the claim line when they are the co-surgeon, operating on the same beneficiary, on same date of surgery.

### Guidance for Providers to Avoid Coding Errors:

- ✓ You may read the “Medicare Claims Processing Manual,” Chapter 12, Section 40.8, Claims for Co-surgeons and Team Surgeons, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>, which provides guidance on billing in cases of co-surgery.
- ✓ You should review the “Global Surgery Fact Sheet,” available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GlobalSurgery-ICN907166.pdf> on the CMS website. This fact sheet describes the use of modifiers related to surgery.



#### Does your documentation support the medical need for the service rendered?

The documentation may include clinical evaluations, physician evaluations, consultations, progress notes, physician’s office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. It is maintained by the physician and/or provider. For more information, please refer to the **“Program Integrity Manual”, Pub 100-08, Chapter 3, Section 3.2.3 A.**



## Recovery Audit Finding: Pre-admission Diagnostic Testing Review

**Provider Types Affected:** Inpatient Hospitals

**Problem Description:** The Recovery Auditors identified pre-admission diagnostic testing services were being reimbursed in addition to reimbursement of the Inpatient Prospective Payment System (IPPS) Hospital for services provided during the defined temporal window as a source of overpayments.

**Medicare Policy:** Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A Coverage.

- The technical portion of all services, other than ambulance and maintenance renal dialysis services that are not diagnostic, provided by the hospital (or an entity wholly owned or operated by the hospital) on the date of a beneficiary's inpatient admission are deemed related to the admission and thus, must be included on the bill for the inpatient stay.
- The technical portion of outpatient non-diagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and the third calendar days (1 calendar day for a

non-subsection (d) hospital) immediately preceding the date of admission are deemed related to the admission and, therefore, must be billed with the inpatient stay, unless the services that are not diagnostic are unrelated to the inpatient hospital claim (that is, the preadmission services that are not diagnostic are clinically distinct or independent from the reason for the beneficiary's inpatient admission).

### Claims examples:

**EXAMPLE 1:** An outpatient claim was submitted for CPT codes 36415 - Routine Venipuncture; 80053 - Comprehensive Metabolic Panel; 86304 - Immunoassay, Tumor, CA 125; 83725 - Assay of Magnesium; and 85025 - Complete CBC w/Diff WBC for date of service 2/18/2011. Patient was admitted to inpatient the same date of service, 2/18/2011. Admitting diagnostic codes were 183.0 Malignant Neoplasm Ovary and V58.11 Antineoplastic Chemotherapy and Immunotherapy.

**Finding:** Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage. For example, if a patient is admitted

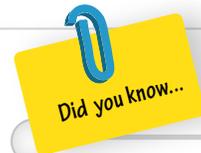
on a Wednesday, outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are included in the inpatient Part A payment.

**EXAMPLE 2:** Outpatient claim was submitted for CPT codes 36415 - Routine Venipuncture; 80053 - Comprehensive Metabolic Panel; 83615 - Lactate (LD) (LDH) Enzyme; 85025 - Complete CBC w/ Diff WBC; 86850 - RBC Antibody Screen; 86900 - Blood typing ABO; 86901 - Blood Typing RD (D); and 86923 - Compatibility Test for date of service 3/15/2011, and patient was admitted to inpatient on the following day, 3/16/2011. . Admitting diagnostic codes were 285.9 Anemia NOS and 162.8 Malignant Neoplasm Bronchus or Lung NEC.

**Finding:** When a beneficiary receives outpatient hospital services during the day immediately preceding the hospital admission, the outpatient hospital services are treated as inpatient services if the beneficiary has Part A coverage. Hospitals and FIs apply this provision only when the beneficiary is admitted to the hospital before midnight of the day following receipt of outpatient services. The day on which the patient is formally admitted as an inpatient is counted as the first inpatient day. When this provision applies, services are included in the applicable PPS payment and not billed separately. When this provision applies to hospitals and units excluded from the hospital PPS, services are shown on the bill and included in the Part A payment.

## Guidance for Providers to Avoid Coding Errors:

- ✓ Review the “Medicare Claims Processing Manual,” Chapter 3 - Inpatient Hospital Billing, Section 40.3 - Outpatient Services Treated as Inpatient Services, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf> on the CMS website.
- ✓ This provision does not apply to ambulance services and maintenance renal dialysis services. Additionally, Part A services furnished by skilled nursing facilities, home health agencies, and hospices are excluded from the payment window provisions.
- ✓ For hospitals and units excluded from IPPS, this provision applies only to services furnished within one day prior to and including the date of the beneficiary’s admission. The hospitals and units that are excluded from IPPS are: psychiatric hospitals and units; inpatient rehabilitation facilities (IRF) and units; long-term care hospitals (LTCH); children’s hospitals; and cancer hospitals.
- ✓ Critical access hospitals (CAHs) are not subject to the 3-day (nor 1-day) DRG payment window.
- ✓ An entity is considered to be “wholly owned or operated” by the hospital if the hospital is the sole owner or operator. A hospital need not exercise administrative control over a facility in order to operate it. A hospital is considered the sole operator of the facility if the hospital has exclusive responsibility for implementing facility policies (i.e., conducting or overseeing the facilities routine operations), regardless of whether it also has the authority to make the policies.



In order for Medicare to cover a power mobility device (PMD), the supplier must receive the written prescription within 45 days of a face-to-face examination by the treating physician, or discharge from a hospital or nursing home, and before the PMD is delivered. The date of service on the claim must be the date the PMD device is furnished to the patient. A PMD cannot be delivered based on a verbal order. If the supplier delivers the item prior to receipt of a written prescription, the PMD will be denied as non-covered.

For more details, please refer to the Medicare Learning Network® fact sheet on this topic titled, [“Power Mobility Devices \(PMDs\): Complying with Documentation & Coverage Requirements.”](#)



## Recovery Audit Finding: Duplicate Claims

**Provider Types Affected:** Outpatient Facilities

**Problem Description:** The Recovery Auditors conducted an automated review of claims that appear to be duplicates. An issue may exist when duplicate services are billed and reimbursed under Medicare. Outpatient claims submitted by a facility for the same service to a particular individual on a specified date of service that was included in a previously submitted claim will be audited for duplicate payments. Exact duplicate data fields submitted for outpatient facility claims including same member, same provider, same dates of service, same types of services, same place of service, same procedure codes, and same billed amount will be audited for duplicate payments. There are actually claims or claim lines that contain an item or service, or multiple instances of an item or service, for which Medicare payment may be made. Correct coding rules applicable to all billers of health care claims encourage the appropriate use of condition codes or modifiers to identify claims that may appear to be duplicates, but are in fact, not. The claims processing systems contain edits which identify duplicate claims and suspect duplicate claims. All exact duplicate claims or claim lines are automatically denied or rejected (absent appropriate modifiers).

The following two scenarios exemplify reasons for adjustments the Recovery Auditors make in order to align provider payments with Medicare guidelines.

1. A provider received duplicate payments of \$87.45 on 4/13/12 and 5/5/12 for CPT 71020 (Chest x-ray) with billed date of service of 3/29/12. Both claims were billed for same patient, same provider, and same date of service, same charge, same CPT code, and same units, without a modifier. The duplicate billing increased the subscriber's liability by \$53.00.
2. A provider received duplicate payments of \$64.19 on 2/22/12 and 4/20/12 for CPT 77080 (Dual-energy X-ray absorptiometry (DXA), Bone Density axial) with billed date of service of 1/31/12. Both claims were billed for the same patient, same provider, and same date of service, same charge, same CPT code, and same units, **without a modifier.**

### Guidance for Providers to Avoid Coding Errors:

- ✓ **Providers need to include the appropriate modifier when performing multiple diagnostic services on the same day.** Providers, coders, and billing staff should review the claims submitted, and verify that if subsequent claims are submitted for the same beneficiary, for the same date of service, with the same codes, but the claims are verified to be different, then appropriate modifiers be used.
- ✓ Billing of modifier 76 (repeat procedure or service by the same physician or other qualified

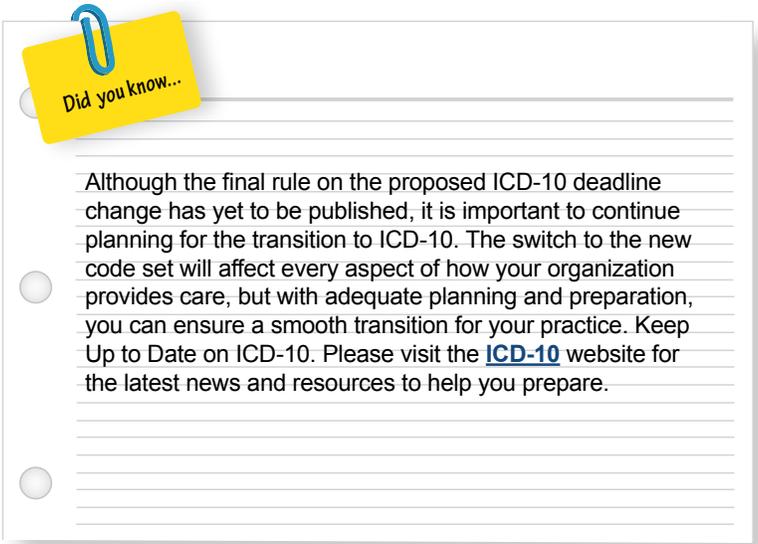
health care professional) or 77 (repeat procedure or service by another physician or other qualified health care professional) should be used to report the performance of multiple diagnostic services on the same day if these were not actually duplicate claims.

- ✓ The following Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes are involved:
  - HCPCS- A codes- Ambulance/ Transportation services
  - HCPCS- B&C codes-Enteral and Parenteral Therapy
  - HCPCS- D codes-Dental Procedures
  - HCPCS-E codes- Durable Medical Equipment
  - HCPCS- G&H codes- Temporary Procedures and Professional Services & Mental Health
  - HCPCS codes-J Codes-Drugs Administered Other Than Oral Method
  - HCPCS codes- L Codes- Orthotic Procedures
  - HCPCS codes-M-P Codes- Medical Services & Pathology/ Laboratory
  - HCPCS codes-Q-R-S Codes- Temporary Codes
  - HCPCS codes-V Codes-Vision Codes
  - CPT codes- Anesthesia-00100 to 01999

- CPT codes-Medicine-90281 to 99607 (excluding E/M 99201 to 99499)
- CPT codes-Path & Lab-80047 to 89356
- CPT codes-Radiology-70010 to 79999
- CPT codes-Surgery-10021 to 69990

**Resources:**

- Review MLN Matters® article MM8121 about the **Clarification of Detection of Duplicate Claims Section of the CMS Internet Only Manual**, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8121.pdf> on the CMS website.
- Review the update to the “Medicare Claims Processing Manual,” Chapter 1, Section 120: “Detection of Duplicate Claims,” which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf> on the CMS website.



Did you know...

Although the final rule on the proposed ICD-10 deadline change has yet to be published, it is important to continue planning for the transition to ICD-10. The switch to the new code set will affect every aspect of how your organization provides care, but with adequate planning and preparation, you can ensure a smooth transition for your practice. Keep Up to Date on ICD-10. Please visit the [ICD-10](#) website for the latest news and resources to help you prepare.



## Recovery Audit Finding: Add-on HCPCS/CPT Codes Without Primary Codes

**Provider Types Affected:** Outpatient Hospitals

**Background:** An add-on code is a HCPCS/CPT code that describes a service that, with one exception (see the Exception paragraph below), is always performed in conjunction with another primary service. An add-on code is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner on the same date of service. An add-on code is never eligible for payment if it is the only procedure reported by a practitioner.

**Exception:** The “Medicare Claims Processing Manual,” Chapter 12, Section 30.6.12(I) requires a provider to report CPT code 99292 (Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)) without its primary code CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) if two or more physicians of the same specialty in a group practice provide critical care services to the same patient on the same date of service. For the same date of service only one physician of the same specialty in the group practice may report CPT code 99291 with or without CPT code 99292, and the other physician(s) must report their critical care services with CPT code 99292.

**Identifying Add-on Codes:** Add-on codes may be identified in three ways:

1. The code is listed in Change Request (CR) 7501 or subsequent CRs as a Type I,

- Type II, or Type III, add-on code.
2. On the Medicare Physician Fee Schedule Database an add-on code generally has a global surgery period of “ZZZ”.
3. In the American Medical Association’s (AMA’s) CPT Manual an add-on code is designated by the symbol “+”. The code descriptor of an add-on code generally includes phrases such as “each additional” or “(List separately in addition to primary procedure).”

### Types of Add-on Codes

CMS has divided add-on codes into three groups to distinguish the payment policy for each group.

**Type I :** A Type I add-on code has a limited number of identifiable primary procedure codes. CR 7501 lists the Type I add-on codes with their acceptable primary procedure codes. A Type I add-on code, with one exception, is eligible for payment if one of the listed primary procedure codes is also eligible for payment to the same practitioner for the same patient on the same date of service. Claims processing contractors must adopt edits to assure that Type I add-on codes are never paid unless a listed primary procedure code is also paid

- As indicated in “Medicare Claims Processing Manual” (Chapter 12, Section 30.6.12(I)) and described in the “Background” section of CR7501 and the “Exception” section above, CPT code 99292 may be paid to a physician who does not report CPT code 99291 if another

physician of the same specialty in his group practice is paid for CPT code 99291 on the same date of service.

**Type II:** A Type II add-on code does not have a specific list of primary procedure codes. CR 7501 lists the Type II add-on codes without any primary procedure codes. Claims processing contractors are encouraged to develop their own lists of primary procedure codes for this type of add-on codes. Like the Type I add-on codes, a Type II add-on code is eligible for payment if an acceptable primary procedure code as determined by the claims processing contractor is also eligible for payment to the same practitioner for the same patient on the same date of service.

**Type III:** A Type III add-on code has some, but not all, specific primary procedure codes identified in the “CPT Manual”. CR7501 lists the Type III add-on codes with the primary procedure codes that are specifically identifiable. However, Medicare’s claims processing contractors are advised that these lists are not exclusive and there are other acceptable primary procedure codes for add-on codes in this Type. Like the Type I add-on codes, a Type III add-on code is eligible for payment if an acceptable primary procedure code as determined by the claims processing contractor is also eligible for payment to the same practitioner for the same patient on the same date of service.

Rarely Medicare contractors may allow, with appropriate submitted documentation, either pre-pay, or on

appeal, payment for a primary code and add-on code on two consecutive dates of service if the services are appropriately related.

**Problem Description:** Recovery Auditors have found that some providers are billing only the add-on codes without their respective primary codes resulting in overpayments. Add-on codes billed without their primary codes are considered an overpayment, with one exception as previously explained in the Background Section above.

**Example:** A provider submitted a claim with CPT Code 26863 for 1 unit for date of service May 5, 2010 without billing for the primary CPT Code 26862.

- Add-on CPT Code 26863  
Description: Fuse/Graft added joint – Arthrodesis, interphalangeal joint with or without internal fixation; with autograft, each additional joint. List separately in addition to code for primary procedure.
- Primary CPT Code 26862  
Description: Fusion/graft of finger – Arthrodesis, interphalangeal joint, without internal fixation; with autograft. This is a parent CPT Code and can be reported with add-on CPT Code 26863.

**Findings:** Add-on codes billed without their primary codes are considered an overpayment. Overpayment for add-on CPT Code 26863 was retracted as a billing error.

### Guidance on How Providers Can Avoid These Problems:

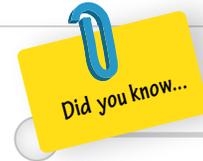
- ✓ An add-on code, with one exception explained previously, is eligible for payment only if it is reported with an appropriate

primary procedure performed by the same practitioner. An add-on code, with one exception, is never eligible for payment if it is the only procedure reported by a practitioner. Providers are advised to use add-on codes with a primary procedure code where appropriate.

- ✓ CMS will update the list of add-on codes with their primary procedure codes on an annual basis before January 1 every year based on changes to the AMA's CPT Manual. In addition quarterly updates will be issued by CMS, as necessary, via a Change Request.

### Resources:

- Use of add-on codes as part of the National Correct Coding Initiative (NCCI) is discussed in the "Medicare Claims Processing Manual" (Chapter 12, Section 30, which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf> on the CMS website.
- Change Request (CR) 7501 (Transmittal 2636 dated January 16, 2013) titled "National Correct Coding Initiative (NCCI) Add-On Codes Replacement of Identical Letter, Dated December 19, 1996 with Subject Line, Correct Coding Initiative Add-On (ZZZ) Codes – ACTION" is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2636CP.pdf> on the CMS website.



A Medicare overpayment is a payment made to a physician or supplier that exceeds amounts due and payable under Medicare statute and regulations. Once the overpayment is determined, the amount becomes a debt owed by the debtor to the Federal government. Federal law requires CMS to seek the recovery of all identified overpayments.



## Recovery Audit Finding: Dose versus Units Billed - Bevacizumab (HCPCS J9035) and Rituximab (HCPCS J9310)

**Provider Types Affected:** Hospitals and Physicians

**Problem Description:** Recovery Auditor reviews of medical records identified errors associated with units of a medication being administered versus units of the medication billed. It was found that improper payments exist due to excessive units being billed for the following drugs:

- Bevacizumab (HCPCS J9035 (Injection, bevacizumab, 10 mg)), or C9257 (Injection, bevacizumab, 0.25 mg), and
- Rituximab (HCPCS J9310 (Injection, rituximab, 100 mg)).

### Example 1: Bevacizumab Claim 1

Recovery Auditors found that a provider billed 1300 units of Bevacizumab (HCPCS J9035 (Injection, bevacizumab, 10 mg)). Because 1 unit equals 10 mg, the 1300 units would represent that 13,000 mg of Bevacizumab was administered to the patient in one day.

**Findings:** It is unlikely that a patient would receive 13,000 mg of Bevacizumab in one day. A review of the patient's medical records verified that 1300 mg of Bevacizumab was administered. Therefore, since 1 unit equals 10 mg, the correct number of units that should have been billed was 130 units and not 1300 units.

### Example 2: Bevacizumab Claim 2

On October 6, 2010, a provider billed HCPCS code J9035 (Injection, bevacizumab, 10 mg) for 1600 units. Since HCPCS code J9035 has 1 unit equal to 10mg, that would mean that this patient received 16,000 mg of Bevacizumab in one day.

**Findings:** It is unlikely that a patient would receive 16,000 mg of Bevacizumab in one day, and when the patient's medical record was reviewed, it was noted that 160 units should have been billed, and not 1600 units.

### Example 3: Rituximab Claim 1

A provider billed HCPCS code J9310 (Injection, rituximab, 100 mg) for 71 units for date of service (DOS) October 27, 2009. Since HCPCS code J9310 has 1 unit equal to 100 mg, receiving 71 units would mean that this patient received 7100 mg of Rituximab for that DOS.

**Findings:** A patient receiving 7100mg of Rituximab seemed abnormal, therefore, the patient's chart was requested. It was found that the patient only received 710 mg and that an incorrect number units were billed. The correct number of units should have been 7.1 and not 71. The 7.1 units was rounded up to 8 units.

### Example 4: Rituximab Claim 2

A provider billed HCPCS code J9310 (Injection, rituximab, 100 mg) for 100 units for DOS April 29, 2010. Again, since HCPCS code J9310 has 1 unit equal to 100 mg, that would mean that this patient received 10,000 mg of Rituximab for that DOS.

**Findings:** A patient receiving 10,000 mg of Rituximab seemed abnormal, and the patient's chart was requested. It was found that the patient only received 1000 mg and that an incorrect number of units were billed. The number of units was adjusted down to 10 units to reflect the proper dosage amount given to the patient.

## Guidance on How Providers Can Avoid These Problems

- ✓ It is important that billing staff use the recurring (annual and quarterly) OPPS updates because HCPCS codes for drugs, biologicals, and radiopharmaceuticals can undergo changes in their HCPCS code descriptors that are effective each new Calendar Year (CY) or quarter. In addition, several temporary codes can be deleted and replaced with permanent HCPCS codes.
- ✓ Providers are strongly encouraged to report charges for all drugs, biological and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. Hospitals should bill for these products making certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug, biological or radiopharmaceutical that was actually administered to the patient and billing for units of service consistent with the dosages contained in the long descriptors of the active HCPCS codes approved for that CY.
- ✓ Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986, P.L. No. 99-509, requires hospitals to report claims for outpatient services using HCPCS codes. The "Medicare Claims Processing Manual," Chapter 4, Section 20.4, states: "The

definition of service units is the number of times the service or procedure being reported was performed.”

✓ Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. If the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4. Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, hospitals should bill 10 units, even though only 1 vial was administered. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

✓ Providers should differentiate between unit billing versus milligram billing on drugs. The definition of service units (FL

46 on the Form CMS-1450) where HCPCS code reporting is required is the number of times the service or procedure being reported was performed. For example, the descriptor for HCPCS code J9035 is “Injection, bevacizumab, 10 mg.” Therefore, when billing for bevacizumab, HCPCS code J9035, 1 unit represents 10mg of bevacizumab. Likewise, the descriptor for HCPCS code J9310 is “Injection, rituximab, 100 mg.” Therefore, when billing for rituximab, HCPCS code J9310, 1 unit represents 100mg of rituximab. Providers should verify the milligrams given and convert to the proper units for billing.

#### Resources:

- “Medicare Claims Processing Manual,” Chapter 17 - Drugs and Biologicals, which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf> on the CMS website;
- MLN Matters® Article MM6857, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6857.pdf> on the CMS website.
- MLN Matters® Article MM6323, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6323.pdf> on the CMS website.

- The Office of Inspector General (OIG) Report titled “Review of High-Dollar Payments for New Mexico and Oklahoma Medicare Part B Claims Processed by Pinnacle Business Solutions, Inc, for the Period January 1 through December 31, 2006” (published April 2009), which is available at <http://oig.hhs.gov/oas/reports/region6/60800071.pdf> on the Internet.
- MLN Matters® Article MM5718, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5718.pdf> on the CMS website.



## Recovery Audit Finding: Mohs Surgery Pathology Billed by Separate Provider

**Provider Types Affected:** Physicians

**Problem Description:** During an audit of the CPT codes associated with Mohs Micrographic Surgery (MMS) across a several state region, auditors found instances in which the preparation and/or interpretation of the slides of tissue removed during the procedures were performed by someone other than the surgeon, or his or her employee.

The following CPT codes were reviewed:

- 17311 – Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks
- 17312 – Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first

stage, up to 5 tissue blocks (list separately in addition to code for primary procedure)

- 17313 – Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks
- 17314 – Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (list separately in addition to code for primary procedure)

- 17315 – Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (list separately in addition to code for primary procedure)

### Examples of Coding Errors:

Below are two examples of errors associated with MMS procedures.

**Example 1:** A physician billed CPT Code 17311 (Mohs Micrographic Surgery), while on the same date of service CPT Code 88305 (Surgical Pathology, gross and microscopic examination) was also billed for the preparation and interpretation of the slides taken during the procedure, performed by someone other than the surgeon or his or her employee.

**Auditor Finding:** CPT Code 17311 was an overpaid claim.



**Example 2:** A physician billed CPT Code 17313 (Mohs Micrographic Surgery) while on the same date of service CPT Code 88305 (Surgical Pathology, gross and microscopic examination) was also billed for the preparation and interpretation of the slides during the procedure, performed by someone other than the surgeon or his or her employee.

**Auditor Finding:** CPT Code 17313 was an overpaid claim.

### Guidance on How Providers Can Avoid These Problems:

- ✓ The physician performing MMS serves both as surgeon and pathologist, performing not only the excision but also the histologic evaluation of the specimens (to facilitate this requirement, the surgical pathology CPT codes 88300-88309 and 88331-88332 and 88342 are bundled into the MMS codes, described above).
- ✓ The majority of skin cancers can be managed by simple excision or destruction techniques. The medical record of a patient undergoing MMS should clearly show that this procedure was chosen because of the complexity (e.g. poorly defined clinical borders, possible deep invasion, prior irradiation), size or location (e.g. maximum conservation of tumor-free tissue is important). Medicare will consider reimbursement for MMS for accepted diagnoses and indications, which you must document in the patient's medical record as being appropriate for MMS and that MMS is the most appropriate choice for the treatment of a particular lesion.

- ✓ Additionally, you should be aware of Mohs Medicare coverage limitations: 1) Only physicians (MD/DO) may perform MMS; 2) The physician performing MMS must be specifically trained and highly skilled in MMS techniques and pathologic identification; and 3) As mentioned above, if the surgeon performing the excision using MMS does not personally provide the histologic evaluation of the specimen(s), the CPT codes for MMS cannot be used, rather the codes (11600-11646) for the standard excision of malignant lesions should be chosen.
- ✓ If MMS on a single site cannot be completed on the same day because the patient could not tolerate further surgery and the additional stages were completed the following day, you must start with the primary code (CPT code 17311) on day two. Computer edits will reject claims where a secondary code (e.g., CPT code 17312) is billed without the primary code (e.g., CPT code 17311) also appearing on same date of service, and the same claim.
- ✓ Your documentation in the patient's medical record should support the medical necessity of this procedure and of the number and locations of the specimens taken. The operative notes and pathology documentation should clearly show that the procedure was performed using accepted MMS technique, in which you acted in two integrated, but distinct, capacities as surgeon and pathologist. The

notes should also contain the location, number, and size of the lesion(s), the number of stages performed, and the number of specimens per stage.

- ✓ You must describe the histology of the specimens taken in the first stage. That description should include depth of invasion, pathological pattern, cell morphology, and, if present, perineural invasion or presence of scar tissue. For subsequent stages, you may note that the pattern and morphology of the tumor (if still seen) is as described for the first stage; or, if differences are found, note the changes. There is no need to repeat the detailed description documented for the first stage, presuming that the description would fit the tumor found on subsequent stages.

### Resources

- You can review the entire Local Coverage Determination (LCD) addressing MMS at [http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=28278&ContrId=175&ver=33&ContrVer=1&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&Keyword=mohs&KeywordLookUp=Title&KeywordSearchType=And&CptHcpcsCode=17311&type=lcd&page=results\\_index.asp&bc=gAAAABAAAAAA%3d%3d&](http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=28278&ContrId=175&ver=33&ContrVer=1&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&Keyword=mohs&KeywordLookUp=Title&KeywordSearchType=And&CptHcpcsCode=17311&type=lcd&page=results_index.asp&bc=gAAAABAAAAAA%3d%3d&) on the CMS website.

## Recovery Audit Finding: Cataract Removal, Part B Number of Units Incorrectly Billed

**Provider Types Affected:** Physicians and Non Physician Practitioners (NPP)

**Background:** Cataract removal can only occur once per eye for the same date of service. This issue identifies overpayments associated to outpatient hospital providers billing more than one unit of cataract removal for the same eye. Additionally according to the "National Correct Coding Initiative Policy Manual for Medicare Services," Chapter 8, Section D #3, cataract removal codes are mutually exclusive of each other and can only be billed once for the same eye.

From the "National Correct Coding Initiative Policy Manual for Medicare Services", "CPT codes describing cataract extraction (66830-66984) are mutually exclusive of one another. Only one code from this CPT code range may be reported for an eye".

**Problem Description:** Recovery Auditors discovered numerous incorrect claims submissions related to cataract removal. The most common cause of improper payments identified for these claim types was incorrectly billing for cataract removal. Cataract removal can only be billed one time per eye. Choose the code that reflects the correct procedure used for removing the cataract.

**Example 1:** For Date of Service (DOS) 10/20/09, the provider billed and received reimbursement for code 66852 LT modifier (Removal of lens material; pars plana approach, with or without vitrectomy) and also 66984 LT modifier (Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage

procedure), manual or mechanical technique). Since these codes are mutually exclusive of one another only one code should have been reimbursed. Per the "NCCI Policy Manual," CPT codes describing cataract extraction (66830-66984) are mutually exclusive of one another. Only one code from this CPT code range may be reported for an eye. Therefore, Medicare received payment for CPT code 66984.

**Example 2:** For DOS 11/23/10, the provider billed and received reimbursement for 2 units of code 66984 66984 RT modifier (Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique). Since cataract removal can only occur once per eye, this would be an overpayment. As a result, Medicare would adjust the units down to 1 for this claim line.

### Guidance on How Providers Can Avoid These Problems:

- ✓ When billing for cataract surgery, care must be taken to not inadvertently bill for similar cataract codes that have been placed in the NCCI edit, and stated to be mutually exclusive. The applicable codes are listed below along with their definitions. They can be found in the "National Correct Coding Initiative Policy Manual for Medicare Services," version 15.3. Chapter 8, Section D, #3. This manual can be downloaded from the National Correct coding Initiative Edits

page found here <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html> on the CMS website.

- CPT 66830 REMOVAL OF SECONDARY MEMBRANOUS CATARACT (OPACIFIED POSTERIOR LENS CAPSULE AND/OR ANTERIOR HYALOID) WITH CORNEO-SCLERAL SECTION, WITH OR WITHOUT IRIDECTOMY (IRIDOCAPSULOTOMY, IRIDOCAPSULECTOMY)
- CPT 66840 REMOVAL OF LENS MATERIAL; ASPIRATION TECHNIQUE, 1 OR MORE STAGES
- CPT 66850 REMOVAL OF LENS MATERIAL; PHACOFRAGMENTATION TECHNIQUE (MECHANICAL OR ULTRASONIC) (EG, PHACOEMULSIFICATION), WITH ASPIRATION
- CPT 66852 REMOVAL OF LENS MATERIAL; PARS PLANA APPROACH, WITH OR WITHOUT VITRECTOMY
- CPT 66920 REMOVAL OF LENS MATERIAL; INTRACAPSULAR
- CPT 66930 REMOVAL OF LENS MATERIAL; INTRACAPSULAR, FOR DISLOCATED LENS
- CPT 66940 REMOVAL OF LENS MATERIAL; EXTRACAPSULAR (OTHER THAN 66840, 66850, 66852)
- CPT 66982 EXTRACAPSULAR CATARACT REMOVAL WITH

INSERTION OF INTRAOCULAR LENS PROSTHESIS (1-STAGE PROCEDURE), MANUAL OR MECHANICAL TECHNIQUE (EG, IRRIGATION AND ASPIRATION OR PHACOEMULSIFICATION)

- CPT 66983 INTRACAPSULAR CATARACT EXTRACTION WITH INSERTION OF INTRAOCULAR LENS PROSTHESIS (1 STAGE PROCEDURE)
- CPT 66984 EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INTRAOCULAR LENS PROSTHESIS (1 STAGE PROCEDURE), MANUAL OR MECHANICAL TECHNIQUE (EG, IRRIGATION AND ASPIRATION OR PHACOEMULSIFICATION)

The above codes are mutually exclusive; one per eye per date of service may be used.

**Resources:**

- The “National Correct Coding Initiative Policy Manual for Medicare Services” is available from the “Downloads” section of <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html> on the CMS website.

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## Recovery Audit Finding: Pulmonary Procedures and Evaluation & Management Services

**Provider Types Affected:** Physicians and non-physician practitioners

**Problem Description:** The Recovery Auditors conducted automated reviews of claims with Evaluation & Management (E&M) Services and Pulmonary Diagnostic Procedures. They identified overpayments associated with evaluation and management services Current Procedural Terminology (CPT) 99211-99213 billed without Modifier 25 on the same date of service as a pulmonary diagnostic procedure (94010-94799).

**Medicare Policy:** If a physician in attendance for a pulmonary function study obtains a history and performs a physical examination related to the pulmonary function testing, separate reporting of an evaluation and management service is not appropriate. If a significant, separately identifiable E&M service is performed unrelated to the performance of the pulmonary function test, an E&M service may be reported with modifier 25.

Here are the definitions of CPT 99211-13, E & M Services and Modifier 25:

- CPT99211 Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
- CPT 99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of 3 key components.

- CPT 99213 Office or other outpatient visit for the evaluation and management of an established patient, low to moderate, 15 minutes of face to face.
- Modifier 25: Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.

### **Billing Considerations:**

- If a physician in attendance for a pulmonary function study obtains a history and performs a physical examination related to the pulmonary function testing, separate reporting of an evaluation and management service is not appropriate.
- If a significant, separately identifiable E & M service is performed unrelated to the performance of the pulmonary function test, an E & M service may be reported with Modifier 25.
- If the evaluation and management was not separately identifiable, then the E & M service should not be reimbursed separately.

### **Billing Examples:**

1. A provider billed CPT code 94010 Breathing capacity test with no modifier for date of service September 19, 2011. The same provider also billed CPT code 99213 Office or other outpatient visit for the evaluation and management of an established patient without any modifier.

CPT code 99213 should not be billed because a physician in attendance for a pulmonary function study obtains a history and performs a physical examination related to the pulmonary function testing. Thus, separate reporting of an evaluation and management service is not appropriate. In this situation, modifier 25 would need to be appended to show if the service was separate and identifiable.

2. A provider billed CPT code 94060 Breathing capacity test with no modifier for date of service February 12, 2011. The same provider also billed CPT code 99212 Office or other outpatient visit for the evaluation and management of an established patient without any modifier.

CPT code 99212 should not be billed because a physician in attendance for a pulmonary function study obtains a history and performs a physical examination related to the pulmonary function testing. Separate reporting of an evaluation and management service is not appropriate. In this situation modifier 25 would need to be appended to show if the service was separate and identifiable.

**Use of CPT Modifier 25, Significant Evaluation and Management Service by Same Physician on Date of Global Procedure:** The “Medicare Claims Processing Manual,” Section 30.6.6, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf> requires that CPT Modifier 25 should only be used on

claims for E & M services, and only when these services are provided by the same physician (or same qualified nonphysician practitioner) to the same patient on the same day as another procedure or other service. Medicare contractors pay for an E & M service provided on the day of a procedure with a global fee period if the physician indicates that the service is for a significant, separately identifiable E & M service that is above and beyond the usual pre- and post-operative work of the procedure. Different diagnoses are not required for reporting the E & M service on the same date as the procedure or other service. Modifier 25 is added to the E & M code on the claim.

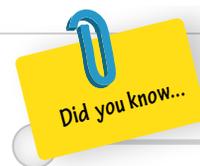
Both the medically necessary E & M service and the procedure must be appropriately and sufficiently documented by the physician or qualified nonphysician practitioner in the patient's medical record to support the claim for these services, even though the documentation is not required to be submitted with the claim.

### Guidance for Providers to Avoid Coding Errors:

- ✓ Review the "Medicare Claims Processing Manual," Section 30.6.6, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>, which requires that CPT Modifier 25 should only be used on claims for E & M services, and only when these services are provided by the same physician (or same qualified nonphysician practitioner) to the same patient on the same day as another procedure or other service. If the E & M services were truly separately identifiable, modifier

25 should be appended. If the E & M services were not separately identifiable, then the E & M should not be reimbursed separately.

- ✓ Review the "Global Surgery Fact Sheet," available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GlobalSurgery-ICN907166.pdf> for more information and examples of billing for E & M services and when to append Modifier 25.



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