

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



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Volume 4, Issue 2 - January 2014

ICN 908994/ January 2014

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This educational tool was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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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 (SNFs), clinical laboratories, ambulance companies, and suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). These contractors are called Medicare Administrative Contractors (MACs) and they process claims, make payments to health care professionals 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 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 second issue in the fourth year of the newsletter.

This issue includes five findings identified by Recovery Auditors and two 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 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 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 on the CMS website.

Comprehensive Error Rate Testing (CERT): Underpayments

Provider Types Affected: Physicians

Background: For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used should be a handwritten or electronic signature. Stamped signatures are not acceptable. Exceptions to this rule are outlined in the Program Integrity Manual (PIM) (<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/PIM83c03.pdf>) as well as MLN Matters® 6698 available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6698.pdf> on the CMS website.

Effective January 1, 2010, the consultation codes are no longer recognized for Medicare Part B payment. Physicians should code patient evaluation and management (E&M) visits with E&M codes that represent where the visit occurs and that identify the complexity of the visit performed. For a detailed description of Consultation Services see Chapter 12, Section 30.6, of the "Medicare Claims Processing Manual," which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf> on the CMS website.

Problem Description: The CERT review contractor determined that a significant number of Medicare FFS claims submitted from July 2010 through June 2011

were underpayments; therefore, the Medicare payments made were improper payments. An improper payment is an incorrect payment because either it is the wrong amount or it is invalid. Legal or other requirements determine whether a payment is improper. Both overpayments and underpayments count as improper payments. An underpayment could result from an improper claim denial, submission, or payment.

CERT Finding: The following scenarios exemplify reasons for adjustments made in order to align provider payments with Medicare guidelines.

Example 1: Surgical Services

A provider billed for a total hip replacement (THA). After the deadline for sending records the provider sent the Centers for Medicare & Medicaid Services (CMS) a note stating that the claim had been coded incorrectly because the beneficiary had a total knee replacement (TKA), not a THA. The provider did not sign the surgery report for a left TKA but sent an attestation to the unsigned report. If a signature is missing from any medical record, other than an order or where the regulations or policy indicate that a signature must be in place prior to a given event or a given date, MACs and the CERT contractor will accept a signature attestation from the author of the medical record.

The "Program Integrity Manual" lists requirements for signature attestation statements. In order to be considered valid for medical review purposes, an attestation statement must be signed and dated by the author of the medical record and must contain sufficient information to identify the beneficiary. Without a signature attestation, the claim is an overpayment for insufficient documentation. CMS re-coded the claim to a TKA, scored it as an underpayment due to incorrect coding and the MAC reimbursed the provider.

Records received more than 75 days after the initial request are late. CMS tries to complete the review process in time for publication of the Health and Human Services Agency Financial Report (AFR). CMS makes determinations on late records even if they are not included in the AFR and tracks late records that reverse determinations.

Example 2: Evaluation and Management (E&M) Services

A provider billed a level three E&M service in an office setting (Healthcare Common Procedure Coding System (HCPCS) 99213). The beneficiary came for a follow-up visit after a visit to the Emergency Room (ER) for chest pain and high blood pressure. The beneficiary continued to have episodes of chest pain and the chest x-ray report from the

ER showed a lung mass. The beneficiary saw a cardiologist, changed medications, had laboratory tests, and had a Chest CT Scan. The record supported a level four E&M service and a code change from 99213 to 99214. This claim was scored as an underpayment due to incorrect coding and the MAC reimbursed the provider.

Example 3: Consultation Services

A provider billed a level five, established patient office visit (HCPCS 99215). The record included a request for a new patient consultation. The record supported a Comprehensive History, Comprehensive Exam, and Moderate Complexity Medical Decision Making for a level four new patient office visit (HCPCS 99204). Because the visit lasted 60 minutes with more than half of the time devoted to going over the findings and recommendations with the patient and his daughter, the record supported a code change from 99215 to 99205. This claim was scored as an underpayment due to incorrect coding and the MAC reimbursed the provider. Medicare does not recognize consultation codes for Medicare Part B payment. Providers should bill for consultations using E/M codes 99201 through 99215.

Guidance on How Providers Can Avoid These Problems:

- ✓ In order to avoid improper payments for E&M services review the Medicare Learning Network Evaluation and Management Services

Guide, the "Medicare Claims Processing Manual," as well as the CERT program on the CMS CERT website. Information about signature guidelines is available on the CMS website.

- ✓ Providers should contact their MAC about reimbursements if the claim was coded incorrectly or if the claim was improperly paid or denied. The CERT contractor notifies the MACs of actual overpayments and underpayments. The MACs recover overpayments and reimburse providers for underpayments.

Resources:

- You may contact your MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.
- The "Medicare Claims Processing Manual," Chapter 12, Section 30.6.10 is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf> on the CMS website.
- MLN® Matters Article MM6698 Signature Guidelines for Medical Review Purposes is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6698.pdf> on the CMS website.

- A Signature Attestation Statement Example is on the CERT Provider Website at <https://www.certprovider.com/SignatureAttestationStatement.aspx> on the Internet.
- The "Program Integrity Manual" (PIM), Chapter 3, Section 3.3.2.4 is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/PIM83c03.pdf> on the CMS website.
- The CERT program website is available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/index.html> on the CMS website.
- The Medicare Learning Network Evaluation and Management Services Guide is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf on the CMS website.



Comprehensive Error Rate Testing (CERT): Unbundling

Provider Types Affected: Physicians, Health Care Professionals, Suppliers

Background: The "Medicare Claims Processing Manual," Chapter 12, Section 20.3, states that there are a number of services/supplies that are covered under Medicare and that have HCPCS codes, but they are services for which Medicare bundles payment into the payment for other related services. If a MAC receives a claim that is solely for a service or supply that must be bundled, the claim for payment should be denied by the MAC because separate payment is never made for routinely bundled services and supplies. The "Medicare Claims Processing Manual," Chapter 8, Section 170 states that MACs make payment on the basis of End-Stage Renal Disease (ESRD) procedure codes, i.e., codes 90935, 90937, 90945, or 90947, only if the place of service on the claim is inpatient hospital. This is because all physicians' outpatient renal-related services are included in payment made under the monthly ESRD capitation payment.

Problem Description: The CERT review contractor determined that Medicare made improper overpayments due to unbundling for Part B claims submitted from July 2010 through June 2011. Intentional unbundling is fraudulent billing. The CERT program randomly samples claims and measures improper payments but does not search for fraud. However, if the CERT contractor suspects fraud while reviewing a claim, it must

make a referral to the appropriate Zone Program Integrity Contractor (ZPIC). The ZPIC develops the case and does an investigation when appropriate. Medicare Part A prohibits unbundling. Unbundling specific parts of a beneficiary's total inpatient care and sending separate claims to Medicare for those tests or treatments is a violation of statute and applicable regulations.

CERT Findings: The following scenarios exemplify reasons for adjustments made in order to align provider payments with Medicare guidelines. All of the following were scored as improper payments due to unbundling.

Example 1: Anesthesia Services

A provider billed for anesthesia services for a vascular shunt procedure (e.g., for dialysis) performed under a regional nerve block (i.e., brachial plexus block) using a code for the procedural anesthesia and a code for a regional nerve block. Because the anesthetic for the procedure was a regional nerve block (i.e., general anesthesia was not used), the regional nerve block is not separately payable and is bundled into the code for the procedural anesthesia. Providers may charge for the regional nerve block separately if general anesthesia is the primary anesthetic, and the regional nerve block is for post-operative analgesia at the request of the surgeon and beneficiary.

Example 2: Evaluation and Management (E&M) Services in the Global Surgical Period

A surgeon billed seven E&M services provided during an inpatient hospital stay for surgery. Progress notes showed that the care provided related solely to the post-operative period. The surgeon did not treat any new medical conditions during those post-operative visits. Therefore, the E&M services are included in the 90-day global surgical period and are not separately billable. It is incorrect to bill for HCPCS 99232 (subsequent hospital care) with modifier 24 (unrelated E&M service by the same physician during a post-operative period) for post-operative care.

Example 3: Dialysis Services

A physician billed initial hospital care at the highest billing level and a hemodialysis procedure with a single evaluation by a physician (or other qualified health care professional) for the same beneficiary for the same date of service. The medical records showed that the beneficiary was evaluated for shortness of breath related to fluid overload from ESRD. The beneficiary had dialysis treatment and was discharged on the same day. The physician only provided an E&M service related to the beneficiary's ESRD, so the E&M service is bundled into the HCPCS code 90935. It is not separately payable.

Example 4: Steroid Injection Services

A single provider billed for diagnostic contrast x-ray (epidurography), fluoroscopic needle placement, AND epidural steroid injection. Because fluoroscopic needle placement is part of the epidurography, it is not separately payable.

Guidance on How Providers Can Avoid These Problems:

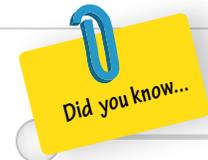
- ✓ Unbundling means billing for each part of a service instead of billing a comprehensive code. For example, if dressings and instruments are included in a fee for a minor procedure, providers may not bill separately for the dressings and instruments. Medicare will not pay for separately billed services when payment is bundled into the payment for other related services. Providers should bill using the HCPCS code that describes the procedure performed to the greatest specificity possible (National Correct Coding Policy Manual). If all the services described by a HCPCS code are performed, it is permissible to bill that code. Multiple HCPCS codes should not be reported if a single HCPCS code describes the services. HCPCS codes include all services usually performed as part of the procedure as a standard of medical or surgical practice. A provider should not separately report these services simply because HCPCS codes

exist for them. If you realize that you coded incorrectly, contact your MAC about potential payment adjustments.

Resources:

- You may contact your MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.
- The "Medicare Claims Processing Manual," Chapter 12, Section 20.3 is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf> on the CMS website.
- The "Medicare Claims Processing Manual," Chapter 8, Section 170 is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c08.pdf> on the CMS website.
- The "National Correct Coding Policy Manual," Hospital APC Version 19.1 is available at <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html> on the CMS website.
- The CERT program website is available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/index.html> on the CMS website.

- The Medicare Learning Network® booklet "How to Use the Medicare National Correct Coding Initiative (NCCI) Tools" is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/How-To-Use-NCCI-Tools.pdf> on the CMS website.



Question:

What is the correct principal diagnosis for a patient who suffers an acute myocardial infarction (AMI) due to underlying coronary artery disease (CAD), in which an interventional procedure is carried out? The consultants are advising coders to sequence the AMI as a secondary diagnosis and the CAD as the principal diagnosis for these cases.

Answer:

No, the consultant's advice is not correct. Sequence the AMI as the principal diagnosis since it is the acute condition and the reason for the admission. You should continue to follow correct coding and reporting practices and report the AMI as the principal diagnosis. This advice is similar to that published in Coding Clinic, Third Quarter 2009, pages 9-10.

Recovery Audit Finding: Anesthesia—Certified Registered Nurse Anesthetist (CRNA) Overpaid

Provider Types Affected: Anesthesiologists, CRNAs

Background: After a review of the Centers for Medicare & Medicaid (CMS) Part B policy and an analysis of data, the Recovery Auditors found a high percentage of errors involving the incorrect use of the HCPCS modifiers for anesthesia. Specifically, anesthesia was provided by a CRNA and Anesthesiologist (physician) without a 50% cutback as per Medicare guidelines involving CRNAs supervised by anesthesiologists.

Problem Description: Reviews by Recovery Auditors determined that when the Anesthesiologist appends modifiers QY, QK, or AD, he/she is stating that the procedure was supervised, and accepts 50% of his/her fee schedule payment. And when for the same service, the CRNA states, through the use of the QZ modifier that the procedure was not supervised, and accepts 100% of their fee schedule, an overpayment to the CRNA exists.

Recovery Auditor Findings:

The following scenarios exemplify reasons for adjustments made in order to align provider payments with Medicare guidelines. The following examples were scored as overpayments.

Example 1: The CRNA billed HCPCS code 00142 (Anesthesia for procedures on eye; lens surgery), with modifier QZ (CRNA service: without medical direction by a physician) for date of service

05/18/2010. However, for the same beneficiary, the same procedure code, and date of service, the anesthesiologist billed with a “QK” modifier (Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals). The billing error resulted in an overpayment.

Example 2: The CRNA billed HCPCS code 01215 (Anesthesia for open procedures involving hip joint; revision of total hip arthroplasty), with modifier QZ (CRNA service: without medical direction by a physician) for date of service 8/1/2011. For the same beneficiary, procedure code, and date of service, the anesthesiologist also submitted a claim with a “QY” modifier (Medical direction of one CRNA by an anesthesiologist). The billing error resulted in an overpayment.

Guidance: How Providers Can Avoid These Problems

- ✓ When submitting bills in cases where the anesthesiologist supervises a case and the CRNA provides the anesthesia services, their total compensation should not exceed 100% of the highest fee schedule of the Anesthesiologist or CRNA. Therefore, when the anesthesiologist appends modifiers QY, QK, or AD, he/she is stating that the

procedure was supervised, and accepts 50% of his/her fee schedule payment. The CRNA must be careful when stating, through the use of the QZ modifier, that the procedure was truly not supervised. If the CRNA is supervised and accepts 100% of the fee schedule, an overpayment to the CRNA exists.

Resources:

- The "Medicare Claims Processing Manual," Chapter 12, Sections 50, 140.4.1, 140.4.2 are available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf> on the CMS website.
- 42 CFR 410.69-Services of a certified registered nurse anesthetist or an anesthesiologist's assistant: Basic rule and definitions is available at <http://www.gpo.gov/fdsys/pkg/CFR-2012-title42-vol2/pdf/CFR-2012-title42-vol2-sec410-71.pdf> on the Internet.
- You may review the Anesthesiologists Center at <http://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html> on the CMS website.

Recovery Audit Finding: Zoledronic acid, (Zometa)—Dose vs. Units Billed

Provider Types Affected: Outpatient Hospitals

Background: After a review of the Centers for Medicare & Medicaid (CMS) medical policies and local coverage determinations (LCDs), Recovery Auditors found a high percentage of errors involving the incorrect use of the HCPCS code J3487—Zometa.

Problem Description: Reviews by Recovery Auditors determined that Zometa represents 1mg per unit and should be billed one (1) unit for every 1mg per patient. Claims for J3487 should be submitted so that the billed units represent the administered units, not the total number of milligrams. Zometa is given as a single 4mg injection and the number of units billed on a claim should be 4.

Recovery Auditor Findings:

The following scenarios exemplify reasons for adjustments made in order to align provider payments with Medicare guidelines. The following examples were scored as overpayments.

Example 1: The provider billed J3487 with 8 units for date of service 6/25/2012. Upon review, it was determined that the drug, Zometa was billed with an incorrect number of units. HCPCS procedure code J3487 states: "injection, Zometa, 1 mg", which was billed as 4 units each on two separate lines totaling 8 units. The medical record does not contain a medication administration record confirming the amount of Zometa infused resulting in an overpayment.

Example 2: The provider billed J3487 on 9/14/2010 with 5 units. Upon review, it was determined that the drug, Zometa was billed with an incorrect number of units. HCPCS procedure code J3487 states, "injection, Zometa, 1 mg", which was billed as 5 units. However, based on the patient's medical chart, 4 mg was infused to the patient. Therefore, 4 units should have been billed, resulting in an overpayment.

Guidance: How Providers Can Avoid These Problems

- ✓ Zometa J3487 should be billed with units given. A unit of J3487 is equivalent to 1mg and Zometa is given as a single 4mg injection and the number of units billed on a claim should be 4. Providers and their billing representative must make sure the billed amount is equivalent to amount administered. Also, remember that for dates of service after June 30, 2013, HCPCS code J3487 will no longer be payable for Medicare claims but is replaced with HCPCS code Q2051.

Providers Note: As of July 1, 2013 HCPCS code J3487 is replaced with HCPCS code Q2051: Injection, Zoledronic Acid, not otherwise specified 1 mg. You may review the MLN® Matters Article MM8268 that describes the code change at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8286.pdf> on the CMS website.

Resources:

- To review the Highlights of Prescribing Information go to: <http://www.pharma.us.novartis.com/product/pi/pdf/Zometa.pdf> on the Internet.
- To review LCDs on the Medicare Coverage Database, go to <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx> on the CMS website.



Recovery Audit Finding: MRI Scans

Provider Types Affected: Part B Professional Services

Problem Description: The Recovery Auditors analyzed claims data for Magnetic Resonance Imaging (MRI) and identified incorrect billing of MRI scans not supported by medical necessity based on local coverage determinations (LCDs).

The National Government Services (NGS) LCD L28518 includes comprehensive lists of The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes that support medical necessity for the MRI scan CPT codes. Potential incorrect billing occurred for claims billed with ICD-9-CM codes that are not supported by medical necessity.

Medical Necessity: The "Medicare National Coverage Determinations Manual," Chapter 1, Part 4, section 220.2 includes general guidelines or examples of what may be considered covered rather than a restrictive list of specific covered indications. Services must be reasonable and necessary.

NGS LCD L28518 states that MRI is covered by Medicare when furnished in accordance with the medical necessity parameters described in this policy. Coverage can be allowed only if all pertinent provisions of this LCD have been met.

Overpayments: The Recovery Auditor found a very high percentage of overpayments in the reviewed claims, but only one underpayment.

Example 1: The provider billed an MRI of the brain/brain stem w/o dye, 70551-26-GC for date of service (DOS) 6/5/09, with ICD-9-CM 310.9, unspecified nonpsychotic mental disorder following organic brain damage.

Auditor Finding: This diagnosis is not considered medically necessary per the LCD.

Example 2: The provider billed for the following MRI procedures:

70551-26-GC, brain/brain stem w/o dye, DOS 6/16/09

72157-26-GC, spinal canal thoracic w/o & w/ dye, DOS 6/16/09

72141-26-GC, spinal canal cervical w/o dye, DOS 6/16/09

72142-26-GC, spinal canal cervical w/ dye, DOS 6/17/09

72147-26-GC, chest spine w/dye, DOS 6/17/09

70552-26-GC, brain/brain stem w/ dye, DOS 6/17/09

All of the above procedures were billed with ICD-9-CM 786.09, other respiratory abnormalities.

Auditor Finding: This diagnosis is not considered medically necessary per the NGS LCD.

Guidance: How Providers Can Avoid These Problems:

You should carefully select the most appropriate diagnosis and be familiar with local coverage determinations. Review the "Medicare National Coverage Determinations Manual," Chapter 1, Section 220.2 (Magnetic Resonance Imaging), which is available at 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) 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.

Recovery Audit Finding: Annual Wellness Visit

Provider Types Affected: Part B Professional Services

Problem Description: Medicare pays for an initial Annual Wellness Visit (AWV), per beneficiary per lifetime. All subsequent wellness visits must be billed as a subsequent Annual Wellness Visit (AWV).

The HCPCS codes to be used in billing the AWVs are:

- G0438 - Annual Wellness Visit, Initial Visit, per beneficiary per lifetime, and
- G0439 - All subsequent wellness visits must be billed as a subsequent AWV.

Example 1: A 76 year old male received an Initial Annual Wellness Visit on March 2, 2011. The physician billed HCPCS Code G0438 (Initial Annual Wellness Visit) and was paid \$195.63. On February 7, 2013, the same beneficiary received another Annual Wellness Visit.

Auditor Finding: The provider billed HCPCS Code G0438 (Initial Annual Wellness Visit) for the 2013 visit, even though the patient had already received the Initial Annual Wellness Visit on date of service March 2, 2011. This resulted in an overpayment.

Example 2: A 75 year old male received an Initial Annual Wellness Visit on March 25, 2011. The physician billed HCPCS Code G0438 (Initial Annual Wellness Visit) and was paid \$183.38. On June 14, 2012, the same

beneficiary received another Annual Wellness Visit.

Auditor Finding: The provider billed HCPCS Code G0438 (Initial Annual Wellness Visit) for the 2012 visit when the patient had already received the Initial Annual Wellness Visit on date of service March 25, 2011. This resulted in an overpayment.

Guidance: How Providers Can Avoid These Problems

You should understand the differences in coding claims for the Initial Annual Wellness Visit and any subsequent wellness visits. Ensure that your billing staffs understand the correct use of HCPCS Codes for Initial and Subsequent Annual Wellness Visits in order to bill the proper codes. Here are some resources that may be helpful tools.

- ✓ The "Medicare Claims Processing Manual," Chapter 12, Section 30.6.1.1(C) provides the Medicare coverage guidelines for AWVs and that portion of the manual is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf> on the CMS website.
- ✓ The Medicare Learning Network® "Quick Reference Information: The ABCs of Providing the Annual Wellness Visit" is a 5-page document

with information in tabular form about AWVs and is available at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_Chart_ICN905706.pdf on the CMS website.

- ✓ The Medicare Learning Network® "Providing the Annual Wellness Visit (AWV)" is an 18-page booklet containing coverage of AWVs, information about documentation, coding and diagnosis, billing requirements, payment and denial, plus resources for physicians. The booklet is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AnnualWellnessVisit-ICN907786.pdf> on the CMS website.



Recovery Audit Finding: Adenosine - Dose vs. Units Billed

Provider Types Affected: Outpatient Hospitals

Problem Description: Medicare Recovery Auditors performed validation of claims for HCPCS code J0152, which is defined in the HCPCS manual as Injection, adenosine for diagnostic use, 30 mg (not to report any adenosine phosphate compounds; instead use A9270).

Adenosine represents 30 mg per unit and should be billed 1 unit for every 30 mg per patient per date of service.

The medication is distributed in 30 mg. amounts. Providers are billing for units representing the mg and not the correct unit of 1 unit for every 30 mg administered.

Example 1: The provider billed HCPCS code J0152 Adenosine injection with date of service 12/21/2011 for 8 units. Medical documentation supported billing for 2 units.

Auditor Finding: The billing error resulted in an overpayment of \$489.42

Example 2: The provider billed HCPCS J0152 Adenosine injection with date of service 12/21/11 for 8 Units. Medical documentnation supported billing for 6 units.

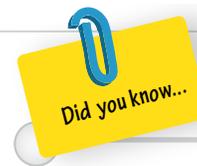
Auditor Finding: The billing error resulted in an overpayment of \$206.16.

Guidance on How Providers Can Avoid These Problems:

- ✓ You should ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the HCPCS long code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor.
- ✓ For example, 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. 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.
- ✓ You 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, bill 10 units, even though only one 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.

- ✓ The correct reporting of units for drugs as described above may be found in 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.

Update: Effective January 1, 2014, there will be a new code, J0151, with a unit of 1 mg, that replaces J0152.



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.”](#)



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ICN 908994/ January 2014