

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



Official Information Health Care
Professionals Can Trust

Medicare Quarterly Provider Compliance Newsletter

Guidance to Address Billing Errors



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

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Archive of Previously-Issued Newsletters

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Introduction

This educational tool is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program. It includes guidance to help health care professionals address and avoid the top issues of the particular Quarter.

There are more than one billion claims processed for the Medicare Fee-For-Service (FFS) program each year. Medicare Administrative Contractors (MACs) process these claims, make payments to more than one million health care professionals in accordance with Medicare regulations, and provide education on how to submit accurately coded claims.

Despite actions to prevent improper payments, it is impossible to prevent them all due to the large volume of claims. The Medicare Learning Network's Medicare Quarterly Provider Compliance Newsletter helps health care professionals to understand the latest findings identified by MACs and other contractors such as Recovery Auditors and the Comprehensive Error Rate Testing (CERT) review contractor, in addition to other governmental organizations such as the Office of the Inspector General (OIG).

The newsletter is released on a quarterly basis. An [archive](#) of previously-issued newsletters, which includes keyword and provider-specific indices, is available on the CMS website.

Provider Types Affected legend:



Hospitals



DMEPOS



Physicians



Skilled Nursing
Facilities



Non-Physician
Practitioners



Recovery Auditor Finding: Hospital Discharge Day Management Service - Different Providers

Provider Types Affected: Hospitals

Problem Description

Only one hospital discharge day management service is payable per patient per hospital stay. Only the attending physician of record reports the discharge day management service.

The Recovery Auditor conducted an automated review of hospital claims in Region D for proper billing for Hospital Discharge Day Management Services. Hospitals in 17 states in Region D submitted 321 incorrect claims for hospital discharge day management services.

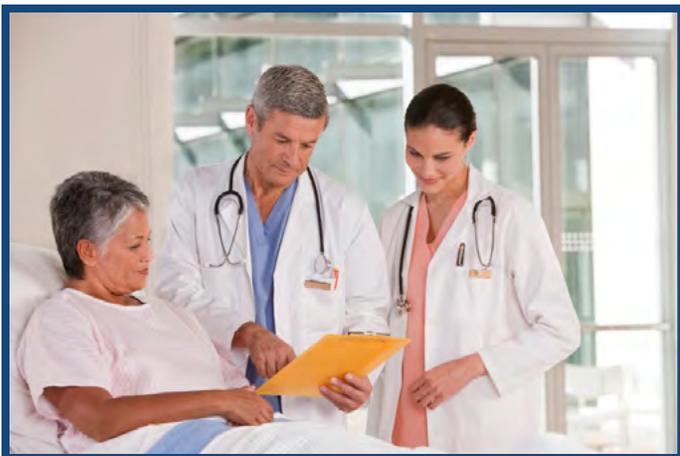
Medicare Policy

Hospital Discharge Day Management Services, CPT code 99238 or 99239, is a face-to-face Evaluation and Management (E/M) service between the attending physician and the patient. The physician or qualified non-physician practitioner must report the E/M discharge day management visit for the date of the actual visit by the physician or qualified non-physician practitioner even if the patient is discharged from the facility on a different calendar date.

Only one hospital discharge day management service is payable per patient per hospital stay. Only the attending physician of record reports the discharge day management service.

Physicians or qualified non-physician practitioners, other than the attending physician, who have been managing concurrent health care problems not primarily managed by the attending physician, and who are not acting on behalf of the attending physician, should use Subsequent

Hospital Care (CPT code range 99231 – 99233) for a final visit. Medicare pays for the paperwork of patient discharge day management through the pre- and post- service work of an E/M service.



What You Should Know

- ◆ Hospitals in 17 States in Region D submitted 321 incorrect claims for hospital discharge day management services.

Helpful Links

The "Medicare Claims Processing Manual," Chapter 12, Section 30.6.9.2, Hospital Discharge Day Management Services, at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

This policy is available in the "Medicare Claims Processing Manual," Chapter 12, Section 30.6.9.2, Hospital Discharge Day Management Services, at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

Guidance for Providers to Avoid Billing Errors

- ✓ Hospital providers should ensure that only the attending physician of record report the discharge day management service.
- ✓ Physicians or qualified non-physician practitioners, other than the attending physician, who have been managing concurrent health care problems not primarily managed by the attending physician, and who are not acting on behalf of the attending physician, must use Subsequent Hospital Care (CPT code range 99231 – 99233) for a final visit.
- ✓ Hospitals should ensure that physicians are aware of these requirements to report the discharge day management service, even if the beneficiary is discharged from the facility on a different calendar date.

Resources

The Medicare manual reference to Hospital Discharge Day Management Services is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf> on the CMS website.



Recovery Auditor Finding: Incorrect Billing of End Stage Renal Disease (ESRD) Codes

Provider Types Affected: Physicians and practitioners managing beneficiaries in dialysis centers

Problem Description

The Recovery Auditors conducted an automated review of claims for ESRD codes. Improper payments were identified where more than one service was billed per month for monthly codes, and where daily codes exceed monthly/daily maximum.

Medicare Policy

Monthly ESRD codes are categorized by the number of visits performed that month and the age of patient. Daily ESRD codes are categorized according to the age of the patient. Affected codes and their short descriptors are:

- CPT 90951 Esrd serv, 4 visits p mo, <2
- CPT 90952 Esrd serv, 2-3 vsts p mo, <2
- CPT 90953 Esrd serv, 1 visit p mo, <2
- CPT 90954 Esrd serv, 4 vsts p mo, 2-11
- CPT 90955 Esrd srv, 2-3 vsts p mo, 2-11
- CPT 90956 Esrd srv, 1 visit p mo, 2-11
- CPT 90957 Esrd srv, 4 vsts p mo, 12-19
- CPT 90958 Esrd srv, 2-3 vsts p mo 12-19
- CPT 90959 Esrd serv, 1 vst p mo, 12-19
- CPT 90960 Esrd srv, 4 visits p mo, 20+
- CPT 90961 Esrd srv, 2-3 vsts p mo, 20+
- CPT 90962 Esrd serv, 1 visit p mo, 20
- CPT 90963 Esrd home pt, serv p mo, <2
- CPT 90964 Esrd home pt, serv p mo, 2-11
- CPT 90965 Esrd home pt, serv p mo 12-19
- CPT 90966 Esrd home pt, serv p mo, 20+
- CPT 90967 Esrd home pt, serv p day, <2
- CPT 90968 Esrd home pt srv p day, 2-11
- CPT 90969 Esrd home pt srv p day 12-19
- CPT 90970 Esrd home pt serv p day, 20+

What You Should Know

- ◆ Overpayments and underpayments were identified where more than one service was billed per month for monthly codes, and where daily codes exceeded the monthly/daily maximum.

Helpful Links

The "Medicare Benefit Policy Manual," Chapter 15, Section 270 Telehealth Services is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf> on the CMS website.

Physicians and practitioners managing center-based patients on dialysis are paid a monthly rate for most outpatient dialysis-related physician services furnished to a Medicare ESRD beneficiary. The payment amount varies based on the number of visits provided within each month and the age of the ESRD beneficiary. Under this methodology, separate codes are billed for providing one visit per month, two to three visits per month and four or more visits per month; a higher payment is provided for two to three visits per month.

To receive the highest payment amount, a physician or practitioner would have to provide at least four ESRD-related visits per month. For ESRD services that are provided less than a full month, per day CPT codes should be used. Overpayments and underpayments were identified where more than one service was billed per month for monthly codes, and where daily codes exceeded the monthly/daily maximums.

Guidance for Providers to Avoid Billing Errors

Physicians should review the guidance in the resources below in order to bill properly for visits and services to beneficiaries in dialysis centers. Here are some key points to consider when billing:

- ✓ The physician or practitioner who provides the complete assessment, establishes the patient's plan of care, and provides the ongoing management is the physician or practitioner who submits the bill for the monthly service.
- ✓ For purposes of billing for physician and practitioner ESRD-related services, the term 'month' means a calendar month. The first month the beneficiary begins dialysis treatments is the date the dialysis treatments begin through the end of the calendar month. Thereafter, the term 'month' refers to a calendar month. The beneficiary's age at the end of the month is the age of the patient for determining the appropriate age related ESRD-related services code.
- ✓ Visits must be furnished face-to-face by a physician, clinical nurse specialist, nurse practitioner, or physician's assistant. The Management Control Plan (MCP) physician or practitioner may use other physicians or qualified non-physician practitioners to provide some of the visits during the month. The MCP physician or practitioner does not have to be present when these other physicians or practitioners provide visits.
- ✓ ESRD-related services with 2 or 3 visits per month and ESRD-related services with 4 or more visits per month may be furnished as a telehealth service. However, at least one visit per month is required in person to examine the vascular access site. A clinical examination of the vascular access site must be furnished face-to-face (not as a telehealth service) by a physician, nurse practitioner or physician's assistant.



Resources

- ✓ MLN Matters Article® MM6349 “Summary of Policies in the 2009 Medicare Physician Fee Schedule (MPFS) and the Telehealth Originating Site Facility Fee Payment Amount” is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6349.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.
- ✓ The "Medicare Claims Processing Manual," Chapter 8, Section 40.1- Payment for ESRD-Related Services Under the Monthly Capitation Payment (Center Based Patients) is available at <http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf> on the CMS website.
- ✓ MLN Matters Article® MM8261 “Revisions to the Medicare Benefit Policy Manual, Chapter 11, End Stage Renal Disease (ESRD) to reflect the Implementation of the ESRD Prospective Payment System (PPS)” is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8261.pdf> on the CMS website.
- ✓ The "Medicare Benefit Policy Manual," Chapter 15, Section 270 Telehealth Services is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf> on the CMS website.



Recovery Auditor Finding: Skilled Nursing Facility (SNF) Level of Care Review

Provider Types Affected: Skilled Nursing Facilities

Problem Description

The Recovery Auditors conducted a complex review of claims submitted by SNFs for level of care. In the SNF, the term “non-covered care” refers to any level of care which is less intensive than the SNF level of care, which is covered under the program.

The Definition of SNF Level of Care

Skilled nursing and skilled rehabilitation services mean services that:

1. Are ordered by a physician;
2. Require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and
3. Are furnished directly by, or under the supervision of, such personnel.

Specific Conditions for Meeting Level of Care Requirements:

1. The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.
2. Those services must be furnished for a condition:
 - i. For which the beneficiary received inpatient hospital, including Critical Access Hospital (CAH) inpatient services; or
 - ii. Which arose while the beneficiary was receiving care in a SNF or swing bed hospital for a condition for which he or she received inpatient hospital or inpatient CAH services; or
 - iii. For which, for a Managed Care enrollee, a physician has determined that a direct admission to a SNF without an inpatient hospital or inpatient CAH stay would be medically appropriate.
3. The daily skilled services must be ones that, as a practical matter, can only be provided in a SNF, on an inpatient basis.

What You Should Know

- ◆ The "Medicare Benefit Policy Manual" states that “skilled observation and assessment may be required for patients whose primary condition and needs are psychiatric in nature or for patients who, in addition to their physical problems, have a secondary psychiatric diagnosis.

Helpful Links

The "Medicare Benefit Policy Manual," Chapter 8, Sections 20.2.2.1 and 20.2.3.2, is available at <http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf> on the CMS website.

Review and Findings

The Recovery Auditors reviewed medical documentation to validate if the patient's stay met the level of care requirements for an inpatient SNF stay. Claims and associated patient medical records showed that the patient's care was primarily psychiatric and did not meet the SNF level of care.

Guidance for Providers to Avoid Billing Errors

The "Medicare Benefit Policy Manual" states that "skilled observation and assessment may be required for patients whose primary condition and needs are psychiatric in nature or for patients who, in addition to their physical problems, have a secondary psychiatric diagnosis. These patients may exhibit acute psychological symptoms such as depression, anxiety or agitation, which require skilled observation and assessment such as observing for indications of suicidal or hostile behavior. However, these conditions often require considerably more specialized, sophisticated nursing techniques and physician attention than is available in most participating SNFs. (SNFs that are primarily engaged in treating psychiatric disorders are precluded by law from participating in Medicare.) Therefore, these cases must be carefully documented."

Resources

Additional information is in:

- ✓ The Medicare regulations on this issue are at 42 CFR 409.31 (Level of Care Requirement), which is available at <http://www.gpo.gov/fdsys/pkg/CFR-2002-title42-vol2/pdf/CFR-2002-title42-vol2-sec409-33.pdf> on the Internet.
- ✓ The "Medicare Benefit Policy Manual," Chapter 8, Sections 20.2.2.1 and 20.2.3.2, is available at <http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf> on the CMS website.





Comprehensive Error Rate Testing (CERT): Implantable Automatic Defibrillators

Provider Types Affected: Hospitals, physicians, and other providers billing for Implantable Automatic Defibrillators.

Problem Description

The Comprehensive Error Rate Testing (CERT) program's special study of Healthcare Common Procedure Coding System (HCPCS) Code 33249 (Insertion or replacement of a permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber) found that many improper payments were made due to insufficient documentation and medical necessity errors.

Implantable automatic defibrillators are electronic devices designed to detect and treat life-threatening rapid heart rates. The device consists of a pulse generator and electrodes for sensing and defibrillating, and they are commonly referred to as Automatic Implantable Cardioverter Defibrillators (AICDs).

Insufficient Documentation and Medical Necessity Errors

Insufficient documentation means that required information is missing from the medical records or is inadequate to support payment. The CERT study found that approximately 85 percent of the improper payments were due to insufficient documentation, and this included lack of:

- Physician's signature on the procedure note;
- Signature log or attestation for cases in which the physician's signature was illegible;
- Electronic record protocol/policy that documents the process for electronic signatures, if applicable;
- Hospital records;
- Records for the specified date of service;
- Records that support the clinical indication for the procedure; or
- Records to support that the beneficiary was enrolled in a clinical study/trial.

In the CERT study, medical necessity errors caused approximately 12 percent of the improper payments. A medical necessity error occurs when the CERT reviewer receives adequate documentation from the medical records submitted to make an informed decision that the services billed were not medically necessary, based upon Medicare coverage policies.

What You Should Know

- ◆ The Comprehensive Error Rate Testing (CERT) program's special study of Healthcare Common Procedure Coding System (HCPCS) Code 33249
- ◆ The CERT study found that approximately 85 percent of the improper payments were due to insufficient documentation

Helpful Links

The "Medicare National Coverage Determinations (NCD) Manual" (Section 20.4; Effective 01/27/2005) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part1.pdf on the CMS website.

For example,

1. For all AICDs, the beneficiary must not have irreversible brain damage from preexisting cerebral disease; also
2. For primary prevention of sudden cardiac death, criteria include that the beneficiary must not have:
 - i. Cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm;
 - ii. Had a Cardiopulmonary Artery Bypass Graft (CABG) surgery or Percutaneous Transluminal Coronary Angioplasty (PTCA) within the past 3 months;
 - iii. Had an acute Myocardial Infarction (MI) within the past 40 days;
 - iv. Clinical symptoms or findings that would make them a candidate for coronary revascularization; or
 - v. Any disease, other than cardiac disease (e.g., cancer, uremia, liver failure), associated with a likelihood of survival less than 1 year.

Examples of Improper Payments for AICDs

Example 1: Improper Payments due to Insufficient Documentation for AICDs

A physician billed for insertion of an AICD using HCPCS 33249 and modifier Q0 (Investigational clinical service provided in a clinical research study).

Review of the documentation found that the following was missing:

1. Clinical documentation supporting a previous Myocardial Infarction (MI) (documented and defined according to the consensus document of the Joint European Society of Cardiology/American College of Cardiology Committee for the Redefinition of Myocardial Infarction);
2. Clinical documentation supporting the defibrillator implantation for primary prevention is enrolled in either:
 - i. A Food and Drug Administration (FDA) approved category B investigational Device Exemption (IDE) clinical trial;
 - ii. A trial under the CMS Clinical Trial Policy; or
 - iii. A qualifying data collection system including approved clinical trials and registries.

The CERT reviewer also received a device implant report for the correct date of service showing implantation of two leads, removal of a previous pacemaker, and threshold testing of the device with induced ventricular fibrillation and shock. The physician signed the report and authenticated the electrophysiology report. Additional information was requested and several unauthenticated clinical records were received that supported the beneficiary's history of heart disease.

However, the beneficiary's condition did not meet the criteria for Medicare coverage of an AICD. Although AICDs that are not covered based on Medicare coverage criteria are covered under Category B IDE trials (42 CFR 405.201; see Resources section below) and the CMS routine clinical trials policy ("National Coverage Determination (NCD) Manual," Chapter 310.1; see Resources section below), there was no documentation of enrollment in a clinical trial in this case.

There was no support for the use of the Q0 modifier in the documentation received, so this claim was scored as an insufficient documentation error and the Medicare Administrative Contractor (MAC) recouped the payment from the provider.

Example 2: Improper Payments due to Insufficient Documentation for AICDs

A physician billed for HCPCS 33249 at time of initial AICD implantation. The submitted documentation showed that the 73 year-old beneficiary had a past medical history of pulmonary hypertension, severe left ventricular dysfunction, non-ischemic dilated cardiomyopathy, dyslipidemia, and congestive heart failure (New York Heart Association Class III). The patient's symptoms included shortness of breath, fatigue, intermittent swelling in his feet, and he was unable to sleep lying flat. He was on maximal medical therapy that included Beta blockers, Angiotensin-Converting Enzyme (ACE) inhibitors, and diuretics. His cardiac catheterization showed an ejection fraction of 30 percent.

An operative report showed that he had an AICD implanted; however, **the date on the report did not match the billed date of service**. Medicare payment rules do not allow reviewers to accept documents with dates that are significantly different from the billed date of service.

This claim was scored as an insufficient documentation error, and the MAC recouped the payment from the provider.

Example 3: Improper Payments due to Medical Necessity Errors for AICDs

A cardiac surgeon billed for HCPCS 33249. He/she submitted medical records showing that the beneficiary had dilated ischemic cardiomyopathy with paroxysmal atrial fibrillation and that he had a Coronary Artery Bypass Graft (CABG) procedure 16 days prior to the AICD implantation.

There was no documentation of a prior MI or of an investigational research study. Documentation included an unsigned post-operative history and physical examination note. The CERT reviewer requested additional documentation to support this claim and received a copy of the previously unsigned post-operative history and physical examination note to which a signature had been added without a signature date.

Note: Providers should not add late signatures to the medical record (beyond the short delay that occurs during the transcription process), but instead should make use of the signature authentication process.

The related NCD requires that the beneficiary must not have had a CABG within 3 months prior to the AICD implantation.

The submitted documentation did not support the NCD requirements for reasonable and necessary services. This claim was scored as a medical necessity error and the MAC recouped the payment from the provider.

Amendments, Corrections and Delayed Entries in Medical Documentation

Providers are encouraged to enter all relevant documents and entries into the medical record at the time they are rendering the service.

A provider may discover that certain entries related to actions that were actually performed at the time of service but not properly documented, need to be amended, corrected, or entered after rendering the service. When making review determinations, the Medicare review contractors consider all submitted entries that comply with the widely accepted Recordkeeping Principles described in the "Medicare Program Integrity Manual," (Section 3.3.2.5 (Amendments, Corrections and Delayed Entries in Medical Documentation), Section B (Recordkeeping Principles); see the Resources section below). MACs, CERT, Recovery Auditors, and Zone Program Integrity Contractors (ZPICs) DO NOT consider any entries that do not comply with the principles listed in Section B, even if such exclusion would lead to a claim denial. For example, Medicare review contractors exclude from consideration undated or unsigned entries handwritten in the margin of a document.

Resources

Providers can find more information on avoiding improper payments for AICD claims at:

- ✓ The National Coverage Determination (NCD) for Implantable Automatic Defibrillators (NCD 20.4) is in the Medicare Coverage Determination Database (Section 20.4; Implantable Automatic Defibrillators) at <http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=110&ncdver=3&bc=AAAgAAAAAAAAA%3d%3d&> or in the "Medicare National Coverage Determinations (NCD) Manual" (Section 20.4; Effective 01/27/2005) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part1.pdf on the CMS website.
- ✓ Category B investigational Device Exemption (IDE) clinical trials (42 CFR 405.201) is available at http://www.ecfr.gov/cgi-bin/text-idx?SID=2a2df55194aaa18b22c7eb778eb55d4a&node=se42.2.405_1201&rgn=div8 on the Internet.
- ✓ The CMS routine clinical trials policy (NCD 310.1) is available in the Medicare Coverage Determination Database (Section 310.1) at <http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=1&ncdver=2&NCAId=186&NcaName=Clinical+Trial+Policy&IsPopup=y&bc=AAAAAAAAAAgAA%3D%3D&> on the CMS website.
- ✓ More information on how to avoid errors on claims for AICDs is available in the "Medicare Program Integrity Manual," (Chapter 3 (Verifying Potential Errors and Taking Corrective Actions); Section 3.3.2.5 (Amendments, Corrections and Delayed Entries in Medical Documentation)), Section B (Recordkeeping Principles) at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf> on the CMS website.



Comprehensive Error Rate Testing (CERT): Polysomnography

Providers Types Affected: Physicians, hospitals, and other providers billing for polysomnography.

Background

Polysomnography (PSG) refers to the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep furnished in a sleep laboratory facility that includes physician review, interpretation and report. A technologist supervises the recording while the patient sleeps and has the ability to intervene, if needed. The studies are performed to diagnose a variety of sleep disorders and to evaluate a patient's response to therapies such as Continuous Positive Airway Pressure (CPAP). PSG is distinguished from sleep studies by the inclusion of sleep staging.

CERT Study

The CERT contractor conducted a special study of the Healthcare Common Procedure Coding System (HCPCS) codes for PSG listed below:

- 95810 Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist
- 95811 Polysomnography; sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist

Findings: Insufficient Documentation Causes Most Improper Payments

Insufficient documentation caused approximately 97 percent of the improper payments. Insufficient documentation means that something was missing from the medical records. For example, there was:

- No valid order for the PSG (if there is no order, evidence of the intent to order PSG documented in the medical record can be accepted);
- No physician's signature on the procedure note; or
- No documentation of the patient's clinical condition to support the need for the PSG study (e.g., missing documentation to support the fact that the beneficiary had symptoms and signs of sleep apnea).

What You Should Know

- ◆ Insufficient documentation caused approximately 97 percent of the improper payments. Insufficient documentation means that something was missing from the medical records.

Helpful Links

Local Coverage Determinations and Local Coverage Articles are available at <http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html> on the CMS website.

Example 1: Improper Payments due to Insufficient documentation for PSG

A pulmonary disease specialist billed for PSG using HCPCS 95810 with modifier 26, which is for the professional interpretation and reporting of the sleep test. The documentation reviewed was missing the following:

1. Physician's order for the diagnostic study or documentation to support the intent to order study; and
2. Clinical documentation to support the reason/need for the diagnostic study.

The CERT reviewer received a copy of a progress note dated six weeks after the date of service. The progress note documented an assessment for obstructive sleep apnea and included a beneficiary information sheet and sleep questionnaire. The CERT reviewer requested additional documentation from the billing provider and received a cardiac catheterization report and a duplicate PSG report.

Finding: The submitted documentation is insufficient to support the service billed per Medicare requirements. The submitted documentation did not support the documentation requirements in the NCD. This claim was scored as an insufficient documentation error and the MAC recouped the payment from the provider.

Example 2: Improper Payments due to Insufficient Documentation for PSG

A neurologist billed for PSG using HCPCS 95811: sleep staging with 4 or more additional parameters of sleep, attended by a technologist. The documentation reviewed was missing the clinical documentation to support the reason/need for the diagnostic study.

The CERT reviewer received the treating physician's signed order for the sleep study dated one month prior to the signed PSG report. However, the treating physician's clinical documentation supporting the medical necessity of the billed PSG was missing. The CERT reviewer made another request for documentation and received a progress note dated a week after the PSG report.

Finding: The submitted documentation is insufficient to support the service billed per Medicare requirements. The submitted documentation did not support the documentation requirements in the National Coverage Determination (NCD). This claim was scored as an insufficient documentation error and the MAC recouped the payment from the provider.

Guidance on How Providers Can Avoid These Problems

Providers should ensure that:

- There is a valid order for the PSG;
- There is a physician's signature on the procedure note; and
- There is documentation of the patient's clinical condition to support the need for the PSG study.

Resources

Providers can find more information on avoiding improper payments for PSG claims at:

- ✓ The MLN Matters® Number MM6534 “Sleep Testing for Obstructive Sleep Apnea (OSA)” is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6534.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.
- ✓ The MLN Matters® Number MM3843 “Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA)” is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM3843.pdf> on the CMS website.
- ✓ The "Medicare National Coverage Determinations Manual," Part 4, Section 240.4.1, – National Coverage Determination (NCD) for Sleep Testing for Obstructive Sleep Apnea (OSA) (Effective March 3, 2009) is available at <http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1Part4.pdf> on the CMS website.
- ✓ The Local Coverage Determinations and Local Coverage Articles are available at <http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html> on the CMS website.
- ✓ The "Medicare Benefit Policy Manual," Chapter 15, Section 70, Sleep Disorder Clinics, is available at <http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf> on the CMS website.



Comprehensive Error Rate Testing (CERT): Skilled Nursing Facility Certifications and Re-certifications

P

NPPs

SNFs

Provider Types Affected: Physicians and Non-Physician Practitioners (NPPs) who bill for services related to beneficiaries in Skilled Nursing Facilities (SNFs).

Problem Description

The SNF inpatient improper payment rate increased from 4.8 percent during the 2012 report period to 7.7 percent during the 2013 report period. A major source of improper payments is that SNFs fail to obtain certification and recertification statements from physicians or Non-Physician Practitioners (NPPs). The routine admission order established by a physician is not a certification of the necessity for post hospital extended care services for purposes of the program.

What is an acceptable certification statement?

The certification must clearly contain the following information:

1. The individual needs **skilled** nursing care (furnished directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services;
2. Such services are required on a **daily** basis;
3. Such services can only practically be provided in a SNF or swing-bed hospital on an **inpatient** basis;
4. Such services are for an ongoing **condition** for which the individual received inpatient care in a hospital; and
5. A dated signature of the certifying physician or NPP.

What is an acceptable recertification statement(s)?

The recertification statement(s) must contain the following information:

1. The **reasons** for the continued need for post hospital SNF care;
2. The estimated **time** the individual will need to remain in the SNF;
3. **Plans** for home care, if any;

What You Should Know

- ◆ A major source of improper payments is that SNFs fail to obtain certification and recertification statements from physicians or Non-Physician Practitioners, (NPPs).

Helpful Links

A "Skilled Nursing Facility Prospective Payment System Fact Sheet" is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/snfprospaymftcsh.pdf> on the CMS website. This fact sheet provides a good overview of SNF Consolidated Billing.

4. If the reason for continued need for services is a condition that **arose after admission** to the SNF (and while being treated for an ongoing condition for which the individual received inpatient care in a hospital) this must be indicated; and
5. A dated signature of the recertifying physician or NPP.

How and where should physicians (or NPPs) document the certification or recertification statement(s)?

There is no specific format or procedure for documentation of the certification or recertification statement(s) but they must include the content listed above.

For example, if appropriate, the physician or NPP could sign and date a statement that:

1. All of the required information is included in the individual's medical record; and
2. Continued post hospital extended care services are medically necessary.

When should physicians (or NPPs) document the certification or recertification statement(s)?

1. The certification must be obtained at the time of admission or as soon thereafter as is reasonable and practicable.
2. The first recertification is required no later than the **14th day** of post hospital SNF care.
3. Subsequent re-certifications are required at least **every 30 days** after the first recertification.
4. Skilled Nursing Facilities are expected to obtain timely certification and recertification statements. However, delayed certifications and re-certifications will be honored where, for example, there has been an isolated oversight or lapse. Delayed certifications and re-certifications must include an explanation for the delay and any medical or other evidence which the SNF considers relevant for purposes of explaining the delay.

Examples of CERT Findings

Example 1: No Indication of Need for Skilled Care

A physician order dated the day of admission to the SNF stated "resident certified as skilled (Medicare)." There was no indication of the need for daily skilled care, for inpatient services or for services for an ongoing condition for which the individual received inpatient care in a hospital care.

Finding: The certification was not complete.

Example 2: No Certification/Recertification in Medical Record

A record selected by CERT for medical review did not have a certification or recertification statement. In response to a request for additional documentation, the facility submitted an initial certification and a

recertification dated after the dates of service for the claim. There was no explanation of the reason(s) for the delayed certification.

Finding: The medical record did not meet Medicare requirements.

Example 3: Certification Dated Prior to Dates of Service

A SNF medical record contained a 30-day recertification, dated prior to the claim dates of service. There was no initial certification. A request for further documentation resulted in an initial certification and a 14-day recertification, both signed six months after the claim dates of service. In addition, the 30-day recertification was returned with a new date, also well after the claim dates of services. There was no explanation of the reason(s) for the delayed certification.

Finding: This documentation did not meet the requirements for SNF certification and recertification.

Resources

You can find more information on how to avoid SNF claim denials in:

- ✓ The Requirements for Post Hospital Care in the Code of Federal Regulations, 42 CFR 424.20, which is available at <http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol3/pdf/CFR-2010-title42-vol3-sec424-20.pdf> on the Internet.
- ✓ The Certification and Recertification by Physicians for Extended Care Services are in the "Medicare General Information, Eligibility and Entitlement Manual," Chapter 4, Section 40, which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c04.pdf> on the CMS website.
- ✓ The "Medicare Benefit Policy Manual," Chapter 8, Section 40, Coverage of Extended Care (SNF) Services Under Hospital Insurance is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf> on the CMS website
- ✓ The "Medicare Claims Processing Manual," Chapter 6, SNF Inpatient Part A Billing and SNF Consolidated Billing is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf> on the CMS website.
- ✓ A "Skilled Nursing Facility Prospective Payment System Fact Sheet" is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/snfprospaymtfctsht.pdf> on the CMS website.
- ✓ The "Skilled Nursing Facility (SNF) Spell of Illness Quick Reference Chart" is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SNFSpellIllnesschrt.pdf> on the CMS website.

Comprehensive Error Rate Testing (CERT): Medical Reviewers Vexed by Insufficient Documentation

Provider Types Affected: Physicians and other providers who provide services to Medicare beneficiaries.

Problem Description

At times, obtaining documentation for the CERT program is difficult. Often, reviewers must use investigative measures to find the appropriate source of the required documentation, such as when supporting documentation is located with someone other than the billing provider (e.g., the ordering or treating physician or a billing service). Having to employ such measures to obtain all documentation for all claims in a sample the size of CERT (approximately 50,000 sampled claims) would be prohibitively expensive and time-consuming. Accurate measurement of the improper payment rate depends on the availability of supporting medical documentation for review.

The CERT staff (registered nurses and a physician) recently analyzed a small sample of claims with improper payments due to insufficient documentation, and attempted to obtain the missing documentation by:

1. Personally contacting billing providers through telephone calls and faxes;
2. Personally speaking to referring providers and/or their staff, as necessary, to obtain medical records that supported billing providers' claims;
3. Personally requesting and receiving clinician attestation statements for certain medical records that were not signed or had illegible signatures; and
4. Locating providers by searching the Internet and CMS databases not available to the CERT Review Contractor

Even with this intensive follow-up effort, documentation frequently was either not obtained, or did not contain the information necessary to properly pay the claim.

Example of Insufficient Documentation - Retinal Drawings

An ophthalmologist billed for a follow-up appointment for a beneficiary with a history of glaucoma, who was otherwise well. The claim lines included:

- HCPCS 92133 (Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve); and

What You Should Know

- ◆ Chapter 15, Section 220.1.1 of the “Medicare Benefit Policy Manual,” payment is dependent on the certification of the plan of care.
- ◆ Approximately 50,000 sampled claims would be prohibitively expensive and time-consuming.

Helpful Links

The NCD Alphabetical Index at <http://www.cms.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx?bc=BAAAAA AAAAA> on the CMS website.

- HCPCS 92226 (Ophthalmoscopy, extended, with retinal drawing (e.g., for retinal detachment, melanoma), with interpretation and report; subsequent).

The provider did not include a retinal drawing in the requested medical documentation for the sampled date of service. During a telephone interview, after confirming understanding of the specific request for a retinal drawing and for medical records to support the billed services, office staff agreed to find and send the required retinal drawing along with any other records for the date of service. When the medical records arrived, there was only a duplicate of the previously submitted computerized retinal tomograph (i.e., a 3-dimensional photograph of the optic nerve and surrounding retina) without interpretation and report. There was no retinal drawing submitted. Providers cannot bill for retinal drawings unless the drawings are completed and available for medical review. These claim lines (HCPCS 92133 and 92226) were denied and scored as an insufficient documentation error and the MAC recouped the payment from the provider.

Example of Insufficient Documentation - Physical Therapy Plan of Care

A physical therapist billed for therapy services without obtaining a physician's signature on the plan of care. The referring physician's office was contacted and although there was a signed order for physical therapy, it did not contain the elements of the plan of care. During a telephone interview, the provider said that he thought a physician's signature on the plan of care was not required. However, per 42 CFR 424.24, Medicare Part B pays for therapy services only if a physician, or other Non-Physician Practitioner (NPP) with knowledge of the case, certifies the plan of treatment. It must be signed as soon as possible (i.e., as soon as it is obtained, or within 30 days of the initial therapy treatment).

A valid plan of care prescribes the type, amount, frequency, and duration of the physical therapy, occupational therapy, or speech-language pathology services to be furnished to the individual, and indicates the diagnosis and anticipated goals that are consistent with the patient function reporting on claims for services (42 CFR 410.61). A signed order is acceptable as certification if it meets the requirements of the plan of care. Per Chapter 15, Section 220.1.1 of the "Medicare Benefit Policy Manual," payment is dependent on the certification of the plan of care. Per Chapter 15 Section 220.1.3 of the "Medicare Benefit Policy Manual," delayed certification is allowed.

Because delayed certification is allowed, the date the certification is signed is important to determine if it is timely or delayed. The certification must relate to treatment during the interval on the claim. Unless there is reason to believe the plan was not signed appropriately, or it is not timely, no further evidence that the patient was under the care of a physician/



Non-Physician Practitioner (NPP) and that the patient needed the care is required. Without this documentation, the claim was scored an insufficient documentation and the MAC recouped the payment from the provider.

Example of Insufficient Documentation - Non-Physician Practitioners (NPP)

A hospital outpatient facility billed for physician services although the beneficiary was seen solely by an NPP. A telephone interview with the medical records staff at the hospital confirmed that there were no records to support a face-to-face encounter by a physician on the date of service. When an NPP, such as a Nurse Practitioner or a Physician's Assistant, provides services independently, the services must be billed using the NPP's NPI number. Unless a physician performs a substantive part of the face-to-face encounter (for the same patient on the same day) and documents the encounter in the medical record, the NPP's service should not be billed using the physician's NPI number. The claim was scored an insufficient documentation error and the MAC recouped the payment from the provider.

Example of Insufficient Documentation - Pre-Admission Screening Updates for Inpatient Rehabilitation Facilities

An Inpatient Rehabilitation Facility (IRF) submitted a claim for services provided over the course of three weeks. The medical records for this claim contained a comprehensive pre-admission screening performed 72 hours prior to the IRF admission. A comprehensive pre-admission screening conducted by a licensed or certified clinician(s) designated by a rehabilitation physician must occur within 48 hours of admission to an IRF. For this purpose, a rehabilitation physician is defined as a licensed physician with specialized training and experience in inpatient rehabilitation. If more than 48 hours elapse after the screening and before admission to the IRF, it must be updated (42 CFR 412.622). The patient's medical and functional status within the 48 hours immediately preceding the IRF admission must be documented in the patient's medical record. The update is acceptable if conducted in person or by telephone. The IRF failed to provide a valid update to the pre-admission screening. The claim was scored as an insufficient documentation error and the MAC recouped the payment from the provider.

Example of Insufficient Documentation - Critical Care Services

A physician billed for critical care services, HCPCS 99291 (Critical care evaluation and management of the critically ill or critically injured patient; first 30-74 minutes), but the medical record received from the hospital showed only a progress note from morning rounds in the critical care unit. The progress note did not indicate time spent with the patient nor did it document that the beneficiary had a high probability of imminent life threatening deterioration. The physician's progress note did not document high complexity decision making or that the beneficiary required treatment for single or multiple vital organ system failure or to prevent further life threatening deterioration of the beneficiary's condition. Telephone interviews with hospital medical records staff and with the treating physician's medical records staff failed to discover any other documentation related to this date of service for this beneficiary. The claim was scored as an insufficient documentation error and the MAC recouped the payment from the provider.

Resources

You can find more information on how to avoid insufficient documentation errors in the following:

✓ Code of Federal Regulations

- CFR per 42 CFR 424.24 at <http://www.google.com/url?url=http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol3/pdf/CFR-2010-title42-vol3-sec424-24.pdf&rct=j&frm=1&q=&esrc=s&sa=U&ei=nn7U4-CNci3ogTrzILgDg&ved=0CBQQFjAA&usg=AFQjCNHAX556PgDOYBB1TkieBYByFGp0vQ> on the Internet.
- 42 CFR 410.61 at http://www.google.com/url?url=http://www.gpo.gov/fdsys/pkg/CFR-2002-title42-vol2/pdf/CFR-2002-title42-vol2-sec410-61.pdf&rct=j&frm=1&q=&esrc=s&sa=U&ei=gnr7U6L_GcbkoAT274KIBQ&ved=0CBQQFjAA&usg=AFQjCNFN1i6l8eqM8vp-4tePhMj7yY2zvq on the Internet.
- 42 CFR 412.622 at http://www.google.com/url?url=http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec412-622.pdf&rct=j&frm=1&q=&esrc=s&sa=U&ei=fnz7U_iaMZW6ogTwx4DQAQ&ved=0CBQQFjAA&usg=AFQjCNG41Rw79nXNZVVSPcsWZLNZ5uLzHpA on the Internet.

✓ Medicare Manuals

- The "Medicare Benefit Policy Manual" Chapter 15 (Covered Medical and Other Health Services), Sections 220.1.1 (Care of a Physician/Non-Physician Practitioner (NPP)) and 220.1.3 (Certification and Recertification of Need for Treatment and Therapy Plans of Care) at <http://www.cms.gov/manuals/Downloads/bp102c15.pdf> on the Centers for Medicare & Medicaid (CMS) website.

✓ National Coverage Determinations (NCD)

- NCD Alphabetical Index at <http://www.cms.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx?bc=BAAAAAAAAAAAA> on the CMS website.

✓ Local Coverage Determinations (LCD)

- LCD Alphabetical Index at <http://www.cms.gov/medicare-coverage-database/indexes/lcd-alphabetical-index.aspx?bc=AgAAAAAAAAAAAA&> on the CMS website.

✓ Medicare Learning Network® MLN Matters® Articles

- MLN Matters® provider compliance fast fact archive at <http://www.google.com/url?url=http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/mln-fastfact-archive.pdf&rct=j&frm=1&q=&esrc=s&sa=U&ei=0Yj7U7SNH5PeoATr0YCQDg&ved=0CBoQFjAB&usg=AFQjCNH9wAaMuua9uphhe0W0-tZfPmsz6g> on the CMS website has several articles and other references that address medical record documentation.



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