

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
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See the Introduction
section for more details

Volume 5, Issue 2 - January 2015

ICN 909177/ January 2015

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Archive of Previously-Issued Newsletters

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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ICD-9-CM Notice: The International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official Federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act standard.

Introduction

This newsletter is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Fee-For-Service (FFS) Program. It includes guidance to help health care professionals address and avoid the top issues of the particular Quarter.

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

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

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

Provider Types Affected legend:



Hospitals



DMEPOS



Physicians
Facilities



Skilled Nursing
Practitioners



Non-Physician



Outpatient
Hospitals



Office of the Inspector General (OIG) Report Finding: Hospitals Receiving Overpayments for Replacement Cardiac Devices

Provider Types Affected: Hospitals

Problem Description

As a result of a review, the OIG found that a number of hospitals that received replacement implantable cardiac devices at no cost, or with a full credit for the cost of the device, or a partial credit equal to 50 percent or more of the cost of the device, were receiving overpayments from Medicare Jurisdiction 15 MACs due to billing errors. Hospitals receiving such devices at no cost or with credits must use proper modifiers when submitting claims so that Medicare reimburses the reasonable cost of the device and overpayments do not occur.

Based on an OIG audit and investigation of Jurisdiction 15 MACs, the OIG discovered that hospitals received overpayments when implanting replacement cardiac devices (specifically noted in the OIG report as defibrillators, pacemakers, and associated electrical leads). The audit covered Calendar Year (CY) 2011.

Medicare Policy

The Centers for Medicare & Medicaid Services (CMS) guidance on this issue is found in Chapter 3, Section 100.8 of the “[Medicare Claims Processing Manual](#).” Medicare payments should be reduced when a replacement device (cardiac or otherwise) is received by a hospital at a reduced cost (including no cost) or with a credit that is 50 percent or greater than the cost of the device.

Correct billing in such situations requires providers to use a combination of Condition Codes 49 or 50, along with Value Code “FD.” Condition Codes 49 and 50 identify a replacement device while Value Code “FD,” informs Medicare of the amount of the credit or cost reduction received by the provider for the replaced device. That credit, whether full or partial, is then deducted from the Medicare reimbursement to the provider.

Prior to January 1, 2014, CMS recognized the modifier FB (Item provided without cost to provider, supplier, or practitioner, or credit received for replaced device) and modifier FC (Partial credit received for replaced device) to identify devices that were furnished without cost or with a full or partial credit. Current policy, as explained in MLN Matters® article [MM8653](#), as well as in Chapter 4, Section 61.3 of the “[Medicare Claims Processing Manual](#),” requires that when a hospital furnishes a new replacement device received with or without cost or with a credit of 50 percent or more of the cost of a new replacement from a

What You Should Know

- ◆ OIG found that in CY 2011, hospitals in Jurisdiction 15 received overpayments in 86 of 641 inpatient and outpatient claims for replacement cardiac medical devices that were audited. These overpayments cost Medicare \$547,553.

Helpful Links

The complete OIG report detailing the audit and its results is available at <http://oig.hhs.gov/oas/reports/region5/51300029.pdf> on the OIG portion of the Department of Health and Human Services (HHS) website.

manufacturer, due to warranty, recall, or field action, the hospital must report the amount of the device credit in the amount portion of Value Code “FD.” Also, hospitals must report Condition Codes 49 or 50 when “FD” is present on the claim.

- Condition Code 49 – Product Replacement Within Product Lifecycle: Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly.
- Condition Code 50 – Product Replacement for Known Recall of a Product: Manufacturer or FDA has identified the product for recall and therefore replacement.

Federal governance regarding this issue is found in 42 CFR 412.89, “[Payment Adjustment for Certain Replaced Devices.](#)”

Guidance for Providers to Avoid Billing Errors

- ✓ Hospitals receiving cardiac devices at reduced or no cost should use the proper Condition Codes and Value Code when submitting claims to ensure overpayments are not made by Medicare.
- ✓ Hospitals should ensure billing staff is aware of rules regarding billing for replacement devices based on guidance found in the “Claims Processing Manual” and 42 CFR 412.89.

Resources

- ✓ Chapter 3, Section 100.8 of the “Medicare Claims Processing Manual” is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf> on the CMS website.
- ✓ Chapter 4, Section 61.3 is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf> on the CMS website.
- ✓ The full text of 42 CFR 412.89 is available at <http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol2/pdf/CFR-2010-title42-vol2-sec412-89.pdf> on the Internet.
- ✓ MLN Matters® Article MM8653 is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8653.pdf> on the CMS website.

Recovery Auditor Finding: Extracorporeal Photopheresis Code 36522 (outpatient)

Provider Types Affected: Outpatient Hospitals

Problem Description

Current Procedural Terminology (CPT) Code 36522 Photopheresis, extracorporeal cannot be billed without diagnosis codes: 202.10-202.18 Mycosis fungoides; 202.20-202.28 Sezary's disease; 996.83 Complications of transplanted heart; 996.85 Complications of transplanted bone marrow.

Upon implementation of ICD-10, the ICD-10-CM diagnosis codes for these conditions are as follows: C84.00- C84.09 Mycosis fungoides; C84.10 – C84.19 Sezary's disease; T86.20 – T86.298 Complications of heart transplant; T86.30 – T86.39 Complications of heart-lung transplant; T86.00- T86.09 Complications of transplanted bone marrow.

Background

Extracorporeal photopheresis is a second-line treatment for a variety of oncological and autoimmune disorders that is performed in the hospital inpatient, hospital outpatient, and critical access hospital settings in which a patient's white blood cells are exposed first to the drug 8-methoxypsoralen (8-MOP) and then to ultraviolet A (UVA) light. The drug is typically administered directly to the white blood cells after they have been removed from the patient (referred to as ex vivo administration), but the drug can alternatively be administered directly to the patient before the white blood cells are withdrawn. After UVA light exposure, the treated white blood cells are re-infused into the patient. The dead white blood cells, once re-infused into the patient, stimulate multiple different cells and proteins of the patient's immune system in a series of cascading reactions. This activation of the immune system then affects the illness being treated.

Medicare Policy

As of December 19, 2006, Medicare covers extracorporeal photopheresis for the following indications:

- Palliative treatment of skin manifestations of cutaneous T-cell lymphoma that has not responded to other therapy (ICD-9-CM codes 202.10-202.18 and 202.20-202.28 and upon ICD-10 implementation, ICD-10-CM codes C84.00- C84.09 and C84.10 – C84.19);

What You Should Know

- ◆ In 2009, the Recovery Auditors conducted an automated review of claims for CPT Code 36522 Photopheresis, extracorporeal, to determine if the claims also contained one of the following diagnosis codes: 202.10-202.18 and 202.20-202.28, 996.83, or 996.85.

Helpful Links

Read more information about this policy and billing instructions in the MLN Matters® article at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7806.pdf> on the CMS website. This policy was implemented after this audit and is not included in the review.

- Patients with acute cardiac allograft rejection whose disease is refractory to standard immunosuppressive drug treatment (ICD-9-CM code 996.83 and upon ICD-10 implementation, ICD-10-CM codes T86.20 – T86.298 and T86.30 – T86.39); and
- Patients with chronic graft versus host disease whose disease is refractory to standard immunosuppressive drug treatment (ICD-9-CM code 996.85 and upon ICD-10 implementation, ICD-10-CM codes T86.00- T86.09).

In 2009, the Recovery Auditors conducted an automated review of claims for CPT Code 36522 Photopheresis, extracorporeal, to determine if the claims also contained one of the following diagnosis codes: 202.10-202.18 and 202.20-202.28, 99683, or 99685.

Finding

The Recovery Auditor determined that a number of claims failed the review, resulting in overpayments.

Guidance for Providers to Avoid Billing Errors

- ✓ Medicare providers should review the National Coverage Determination (NCD) and the billing instructions in order to bill properly for extracorporeal photopheresis for Medicare beneficiaries.
- ✓ The NCD for Extracorporeal Photopheresis 110.4, is available at <http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=113&ncdver=3&bc=AgAAQAAAAAAAAAA%3D%3D&> on the CMS website.
- ✓ You may also want to review the “Medicare Claims Processing Manual,” Ch. 32, Billing Requirements for Special Services, which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1206CP.pdf> on the CMS website.

NOTE: Effective for claims with dates of service on or after April 30, 2012, CMS will cover extracorporeal photopheresis for the treatment of bronchiolitis obliterans syndrome (BOS) following lung allograft transplantation only when extracorporeal photopheresis is provided under a clinical research study that meets certain conditions. Read more information about this policy and billing instructions in the MLN Matters® article at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7806.pdf> on the CMS website. This policy was implemented after this audit and is not included in the review.



Recovery Auditor Finding: Facet Joint Injections

Provider Types Affected: Outpatient Hospitals and Physicians

Problem Description

The Local Coverage Determination (LCD) policy (see http://downloads.cms.gov/medicare-coverage-database/lcd-attachments/29252_7/64490.2_codeguide.htm) indicates approved covered conditions for Facet Joint Injections. In automated reviews in 2011, the Recovery Auditors identified claims where the first-listed and/or other diagnosis codes do not match to the covered diagnosis codes in the LCD policies. An overpayment exists when a provider bills for a Facet Joint Injection with an International Classification of Diseases 9th Edition Clinical Modification (ICD-9) code that is not included in the list of covered ICD-9 codes within the applicable LCD documents for Facet Joint Injections.

Medicare Policy

Medicare will consider facet joint blocks to be reasonable and necessary for chronic pain (persistent pain for three (3) months or greater) suspected to originate from the facet joint. Facet joint block is one of the methods used to document and confirm suspicions of posterior element biomechanical pain of the spine. Hallmarks of posterior element biomechanical pain are:

- The pain does not have a strong radicular component.
- There is no associated neurological deficit and the pain is aggravated by hyperextension, rotation or lateral bending of the spine, depending on the orientation of the facet joint at that level.

A paravertebral facet joint represents the articulation of the posterior elements of one vertebra with its neighboring vertebrae. The facet joint is noted at a specific level by the vertebrae that form it (e.g., C4-5 or L2-3). It is further noted that there are two (2) facet joints at each level, left and right. The covered Current Procedural Terminology (CPT) codes reviewed are:

- CPT 64490 -Injections(s), diagnostic injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level

What You Should Know

- ◆ MLN Matters® Article MM6518 (Appropriate Use of Modifier 50 and Add-On Current Procedural Terminology Codes (CPT) for Facet Joint Injection Services) clarifies the appropriate use of modifier 50 and add-on codes for facet joint injection services.

Helpful Links

Department of Health and Human Services Inspector General Report, entitled, "Medicare Payments for Facet Joint Injections Services," (2008) is available at <http://oig.hhs.gov/oei/reports/oei-05-07-00200.pdf> on the Internet.

- CPT 64491 - Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level
- CPT 64492 - Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s)
- CPT 64493 - Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
- CPT 64494 - Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level
- CPT 64495 - Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s)
- CPT 64622 - Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level
- CPT 64623 - Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (list separately in addition to code for primary procedure)
- CPT 64626 - Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level
- CPT 64627 - Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (list separately in addition to code for primary procedure)
- CPT 64999 - Unlisted procedure, nervous system
- CPT 77003 - Fluoroguide for spine inject

Discussion of Codes

Because of the diagnostic nature of facet blocks, precise localization is necessary. Therefore, it is expected that use of the facet codes (CPT 64490-64495) would require radiologic localization (i.e., fluoroscopy). An injection may be placed in the facet joint itself or around the medial branch nerve innervating the joint. In general, it is believed that two to three medial branch nerves innervate each lumbar facet joint and two nerves innervate each cervical or thoracic facet joint. These nerves are the branches of the posterior division of the spinal nerves, located immediately above and below the joint.

- CPT codes 64490 and 64493 are intended to be used to report all of the nerves that innervate the first level paravertebral facet joint and not each nerve.
- CPT codes 64491, 64492, and 64494, 64495 are intended to report second and third additional levels paravertebral facet joints and not each additional nerve. Facet joint levels refer to the joints that are blocked and not the number of medial branches that innervate them as defined by the American Medical Association (AMA) CPT Committee.
- Codes 64490-64495 are unilateral procedures.

- When bilateral injections are performed (e.g., injections performed at both the left and right paravertebral facet joints), then the bilateral modifier 50 should be appended to the appropriate code. Note that the multiple procedures modifier 51 should not be appended to the add-on codes 64491, 64492, 64494, or 64495 because these are add-on codes and exempt from multiple procedure concept.

The cervical/thoracic facet injection codes (64490, 64491, and 64492) and lumbar/sacral facet joint injection codes (64493, 64494, and 64495) are reported once when the injection procedure is performed irrespective of whether a single or multiple puncture is required to anesthetize the target joint at a given level and side. To clarify, only one facet injection code should be reported at a specific level and side injected (e.g., right L4-5 facet joint), regardless of the number of needle(s) inserted or number of drug(s) injected at that specific level.

MLN Matters® Article MM6518 (Appropriate Use of Modifier 50 and Add-On Current Procedural Terminology Codes (CPT) for Facet Joint Injection Services at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm6518.pdf>) clarifies the appropriate use of modifier 50 and add-on codes for facet joint injection services.

- Physicians who perform facet joint injections on both the right and left sides of one level of the spine must use modifier 50 with the appropriate CPT codes when submitting claims. If a physician performs multiple bilateral injections, modifier 50 should accompany each facet CPT joint injection code.
- Physicians who perform facet joint injections on multiple levels on the same side of the spine must use the CPT add-on codes to represent these additional levels injected, instead of using modifier 50.

Guidance for Providers to Avoid Coding Errors

Physicians are encouraged to review the following resources which explain in greater detail the Medicare policy for facet joint injections:

- ✓ MLN Matters® Article MM6518 "Appropriate Use of Modifier 50 and Add-On Current Procedural Terminology Codes (CPT) for Facet Joint Injection Services" is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6518.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.
- ✓ The specific LCD quoted above is at http://downloads.cms.gov/medicare-coverage-database/lcd_attachments/29252_7/64490.2_codeguide.htm on the CMS website. Other LCDs for facet joint injections services are available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?q=true> on the CMS website. Once at that site, use the "Quick Search" function on the right side of the screen to search for LCDs related to facet joints or any other search terms you wish to find.
- ✓ Department of Health and Human Services Inspector General Report, entitled, "Medicare Payments for Facet Joint Injections Services," (2008) is available at <http://oig.hhs.gov/oei/reports/oei-05-07-00200.pdf> on the Internet.

Recovery Auditor Finding: Duplicate Claims

Provider Types Affected: Physicians

Problem Description

Recovery Auditors reviewed claims submitted by the same physicians for the same service to a particular individual on a specified date of service that was included in a previously submitted claim (excluding interim billing or corrected claims). The claims were for duplicate payments. This audit was conducted in 17 States in 2010.

Exact duplicate data fields submitted for physician claims, including same member, same provider, same dates of service (not including interim billing or corrected claims), same types of services, same place of service, same procedure codes, same provider, and same billed amount were audited for duplicate payments. The Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes that were examined in this review include:

- HCPCS A Codes 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 Procedures and Professional Services
- HCPCS J Codes Drugs Administered Other than Oral Method
- HCPCS L Codes Orthotic Procedures
- HCPCS M-P Codes Medical Services
- HCPCS Q-R-S Temporary Codes
- HCPCS V Codes Vision Services
- CPT Anesthesia 00100 to 01999
- CPT Medicine 90281 to 99607 (excluding E/M 99201 to 99499)
- CPT Path & Lab 80047 to 89356
- CPT Radiology 70010 to 79999
- CPT Surgery 10021 to 69990

What You Should Know

- ◆ The Centers for Medicare & Medicaid Services (CMS) will pay the first claim that is approved and will deny subsequent claims for the same service as duplicates.

Helpful Links

If you do not know the MAC's toll-free number, you can find it at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/> on the CMS website.

Medicare Policy

The “Medicare Claims Processing Manual,” Chapter 1, Section 120 (Claims Submitted by Physicians, Practitioners, and other Suppliers (except DMEPOS Suppliers)), states that claims or claim lines that have been determined to be exact duplicates of another claim or claim line are denied. However, such denials may be appealed. An exact duplicate for physician and other supplier claims submitted to a Medicare Administrative Contractor (MAC) is a claim or claim line that exactly matches another claim or claim line with respect to the following elements:

- Health Insurance Claim (HIC) Number;
- Provider Number;
- From Date of Service;
- Through Date of Service;
- Type of Service;
- Procedure Code;
- Place of Service; and
- Billed Amount.

MLN Matters® Article SE0415 (listed in the Resources below) states that a duplicate claim is a claim submitted to one or more MACs from the same provider for the:

- Same beneficiary;
- Same item or service; and
- Same date of service.

Submitting duplicate claims for the same service encounter is inappropriate. Medicare does not make payment for duplicate claims that you might submit. The Centers for Medicare & Medicaid Services (CMS) will pay the first claim that is approved and will deny subsequent claims for the same service as duplicates. Although Medicare is prohibited by law from paying claims immediately, over 90 percent of clean, payable claims are paid within 30 days.

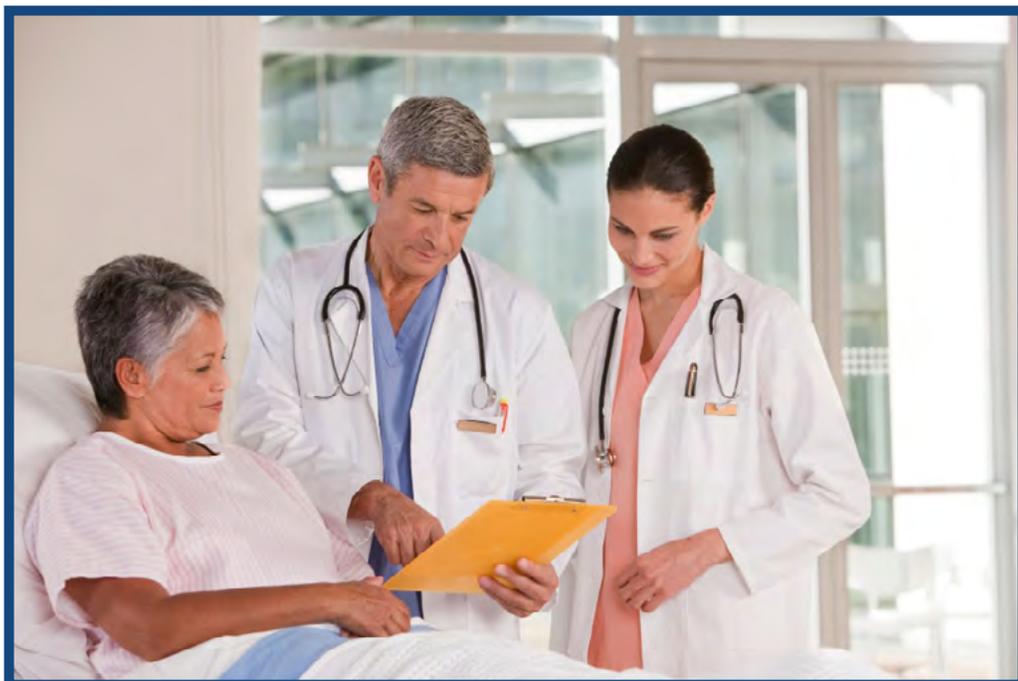
Therefore, once you submit a claim, do not keep re-submitting until you get paid. One submission is all that is required. CMS suggests that, if you have not received payment after 30 days and are concerned about your payment, contact your MAC via their toll-free lines to check on claims status or use other electronic claims status inquiry functions to check with your MAC on claim status.

If you do not know the MAC’s toll-free number, you can find it at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/> on the CMS website.

Guidance for Providers to Avoid Coding Errors

Providers are encouraged to review the following resources to ensure that they are not submitting duplicate claims:

- ✓ The "Medicare Claims Processing Manual," Chapter 1, Section 120, Detection of Duplicate Claims, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf> on the CMS website.
- ✓ MLN Matters® Article SE1314 "Duplicate Claims – Outpatient" is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1314.pdf> on the CMS website.
- ✓ MLN Matters® Article MM8121 "Clarification of Detection of Duplicate Claims Section of the CMS Internet Only Manual" is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8121.pdf> on the CMS website.
- ✓ MLN Matters® Article SE1036 "Recovery Audit Contractor (RAC) Demonstration High-Risk Vulnerabilities for Physicians" is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1036.pdf> on the CMS website.
- ✓ MLN Matters® Article SE0415 "Reminder to Stop Duplicate Billings" is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0415.pdf> on the CMS website.



Recovery Auditor Finding: Intravenous Infusion Chemotherapy and Non-chemotherapy- Excessive Units Reported

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Providers Types Affected: Outpatient Hospitals and Physicians

Problem Description

According to the Current Procedural Terminology (CPT), Fourth Edition, as published by the AMA, the provider of medical services is to report all services by way of the AMA-CPT Code, which most accurately reflects the service provided, according to the definition of said code.

Five AMA-CPT Codes are the focus of this audit:

- 96413 – Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug;
- 90765 – Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour (Effective Date Range: Through 12/31/2008);
- 96365 – Intravenous infusion, for therapy, prophylaxis or diagnosis (specify substance or drug); initial, up to 1 hour (01/01/2009-present);
- 90769 – Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour, including pump set-up and establishment of subcutaneous infusion site(s) (Effective Date Range: 01/01/2008 –12/31/2008); and
- 96369 – Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour, including pump set-up and establishment of subcutaneous infusion site(s) (Effective Date Range: 01/01/2009-present).

Medicare Policy

Each of these codes is to be reported only once per day, according to the “Medicare Claims Processing Manual,” Chapter 12, Section 30.5, which instructs the physician to report only one “initial” service code unless protocol requires that two separate IV sites must be used. If more than one “initial” service code is billed per day, the MAC shall deny the second initial service code, unless the patient has to come back for a separately identifiable service on the same day or has two IV lines per protocol. For these separately identifiable services, instruct the physician to report with modifier 59.

What You Should Know

- ◆ MLN Matters® Article MM3818 states that the definition of the “initial code is amended to state that the initial code best describes the key or primary reason for the encounter and should always be reported irrespective of the order in which the infusions or injections occur.”

Helpful Links

The MLN Matters® Article MM3818 (Revised Coding Guidelines for Drug Administration Codes) is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm3818.pdf> on the CMS website.

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.” In addition, Chapter 1, Section 80.3.2.2, of the manual states: “In order to be processed correctly and promptly, a bill must be completed accurately.”

MLN Matters® Article MM3818 (Revised Coding Guidelines for Drug Administration Codes), states that the definition of the “initial code is amended to state that the initial code best describes the key or primary reason for the encounter and should always be reported irrespective of the order in which the infusions or injections occur.” This is a clarification of the Transmittal 129 definition that the initial code is “the code that best describes the service the patient is receiving and the additional codes are secondary to the initial code.” If more than one initial service code is billed, the carrier will deny the second initial service code using remittance advice remark code of M86 to show that it is not payable unless the patient has to return for a separately identifiable service on the same day or has two IV lines per protocol.

MLN Matters® Article MM6349 (Revised Coding Guidelines for Drug Administration Codes), provides renumbered CPT codes. Effective for CY 2009, the following CPT codes have been renumbered:

Deleted CPT Code	New CPT Code	Short Descriptor
90760	96360	Hydration iv infusion, init
90761	96361	Hydrate iv infusion, add-on
90765	96365	There/proph/diag iv inf, init

The Recovery Auditor conducted an automated review of these codes in order to identify claims in which more than one (1) unit of service is reported and, as a result, over-reimbursed per CMS references are noted in the section below.



Guidance to Provider to Avoid Coding Errors

- Ensure that you understand and comply with the Medicare policy for Codes for Chemotherapy Administration and Non-chemotherapy Injections and Infusion, which states that each of these codes is to be reported only once per day. The physician reports only one “initial” service code unless protocol requires that two separate IV sites must be used.
- If more than one “initial” service code is billed per day, the MAC shall deny the second initial service code, unless the patient has to come back for a separately identifiable service on the same day or has two IV lines per protocol. For these separately identifiable services, the physician reports with modifier 59. Each of these codes is to be reported only once per day.
- The definition of the “initial code” is the code that best describes the key or primary reason for the encounter and should always be reported irrespective of the order in which the infusions or injections occur.

Physicians are encouraged to review the following resources which explain in greater detail the Medicare policy:

- ✓ The “Medicare Claims Processing Manual,” Chapter 12, Section 30.5, 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 20, Section 20.4, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf> on the CMS website.
- ✓ The MLN Matters® Article MM3818 "Revised Coding Guidelines for Drug Administration Codes" is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm3818.pdf> on the CMS website.
- ✓ The MLN Matters® Article MM6349 "Revised Coding Guidelines for Drug Administration Codes" is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6349.pdf> on the CMS website.





Comprehensive Error Rate Testing (CERT): Surgical Procedures Related to Hemodialysis Access

Provider Types Affected: Physicians and Hospitals

Background

For beneficiaries with end-stage renal disease (ESRD) treated with hemodialysis, the preferred vascular access is an arteriovenous fistula (AVF). An AV graft is generally the next best option. An AVF is a connection of an artery to a vein, usually created in the forearm or upper arm to allow repeated needle insertions. Procedures for the creation or revision of an AV fistula or graft and related procedures are usually outpatient services. Inpatient hospital admission is appropriate when the beneficiary has some other acute problem requiring inpatient care or when a serious post-operative complication arises.

Improper Payments Identified Related to Hemodialysis Access

The Comprehensive Error Rate Testing (CERT) program has identified many improper payments related to procedures involving arteriovenous grafts and fistulas. The majority of these improper payments occurred because the facility billed Medicare for the surgery and post-operative care as an inpatient hospital admission.

Medicare payment for surgical procedures includes payment for the procedure itself and for post-operative recovery and monitoring. Billing an inpatient admission is not necessarily appropriate just because post-operative care extends overnight. Most hemodialysis patients undergo dialysis three times a week. Frequently, one of these sessions occurs at the same time as a vascular access-related procedure. However, hemodialysis by itself does not require inpatient hospital care and a beneficiary's need for chronic hemodialysis does not justify an inpatient hospital admission for a vascular access-related procedure.

The most common reason to deny a hospital claim for inpatient admission spanning less than 2 midnights is the physician's failure to document a reasonable



What You Should Know

- ◆ Physicians do not need to include a separate attestation of the expected length of stay; rather, this information may be inferred from the physician's standard medical documentation, such as his or her plan of care, treatment orders, and physician's notes.

Helpful Links

The Centers for Medicare & Medicaid Services (CMS) denial of claims during a "probe & educate" period, is available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/UpdateOnProbeEducateProcessForPosting02242014.pdf> on the CMS website.

expectation that the beneficiary would require a hospital stay that would cross 2 or more midnights. Physicians do not need to include a separate attestation of the expected length of stay; rather, this information may be inferred from the physician's standard medical documentation, such as his or her plan of care, treatment orders, and physician's notes. Expectation of time and the determination of the underlying need for medical care at the hospital are supported by complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event, which are expected to be documented in the physician's assessment and plan of care.

Resources

- ✓ Medicare Inpatient Hospital Probe and Educate Status Update, dated February 24, 2014, provides additional examples and explanations of claim review results and the Centers for Medicare & Medicaid Services (CMS) denial of claims during a "probe & educate" period, available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/UpdateOnProbeEducateProcessForPosting02242014.pdf> on the CMS website.





Comprehensive Error Rate Testing (CERT): Osteogenic Stimulators

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

Background

Sometimes, broken bones do not heal despite proper alignment and fixation. When a broken bone fails to heal and the bone fragments do not reconnect it is called a nonunion. Risk factors for nonunion include preexisting conditions (for example, diabetes, osteoporosis, malignancy, infection) and certain types of injuries (for example, high energy trauma, open fractures, severe soft tissue injury, particular anatomic sites). Broken bones are not the only indication for osteogenic stimulators; for example, they may also be used for failed joint fusions or congenital pseudarthrosis.

Kinds of Osteogenic Stimulators

Osteogenic stimulators are either electrical or ultrasonic devices used to stimulate bone repair.

- Electrical osteogenic stimulators are either invasive (implantable) or noninvasive. A noninvasive electrical osteogenic stimulator uses an external power source, which is attached to a coil or electrodes placed on the skin or on a cast or brace over a fracture or fusion site.
- An ultrasonic osteogenic stimulator emits low intensity pulsed ultrasound waves in order to stimulate healing of a broken bone. The device is applied to the skin surface at the fracture location and uses ultrasound conductive coupling gel.

Medicare Coverage for Osteogenic Stimulators

Medicare coverage for osteogenic stimulators depends on the type of device, the anatomical site, and the details of the nonunion. Specific coverage criteria apply to osteogenic stimulators used as adjunctive treatment for spinal fusions. Medicare excludes some nonunion fractures from coverage, for example, those that are tumor-related.

When an osteogenic stimulator is prescribed for the treatment of the nonunion of a long bone fracture, specific criteria must be met for the device to be covered.

What You Should Know

- ◆ Medicare excludes some nonunion fractures from coverage, for example, those that are tumor-related.

Helpful Links

Local Coverage Determinations and Local Coverage Articles are available at <http://www.cms.gov/Medicare/Coverage/Determination/Process/LCDs.html> on the CMS website.

- Nonunion of long bone fractures is considered to exist only when serial radiographs have confirmed that fracture healing has ceased for 3 or more months prior to starting treatment with an electrical osteogenic stimulator.
- Serial radiographs must include a minimum of 2 sets of radiographs, separated by a minimum of 90 days. Each radiograph must include multiple views of the fracture site.
- The Local Coverage Determinations (LCDs) specify that there must be a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs. The LCDs further specify that a long bone is limited to a clavicle, humerus, radius, ulna, femur, tibia, fibula, metacarpal, or metatarsal.

Insufficient Documentation Causes Most Improper Payments

The Comprehensive Error Rate Testing (CERT) reviewer found improper payments for osteogenic stimulators due to insufficient documentation.

Insufficient documentation means that something was missing from the medical records. For example, there was:

- No valid Certificate of Medical Necessity (CMN) (CMS Form 847) for the osteogenic stimulator;
- No physician's signature on an imaging study report;
- No statement in the imaging study report that there was no clinically significant evidence of fracture healing; or
- No physician's signature on an operative note.

Example of Improper Payments for Osteogenic Stimulators - Insufficient Documentation

A supplier billed for an osteogenic stimulator (HCPCS E0747) for a date of service in 2012. The documentation submitted did not include radiographic evidence that fracture healing had ceased for three or more months prior to starting treatment with the osteogenic stimulator.

The CERT reviewer received a signed and dated Certificate of Medical Necessity (CMN). However, some of the required questions were not answered. The initial x-ray report in the treating physician's progress note stated "x-rays of the right foot are negative." A follow-up bone scan 6 weeks later was reported by the treating physician as showing a "stress reaction" of the fifth metatarsal. The radiologist's interpretation of the bone scan was "mild focal uptake" and he recommended a follow up plain film examination. The submitted progress notes stated that the patient had a clinical diagnosis of a right proximal fifth metatarsal nonunion stress fracture. No repeat x-ray was performed prior to ordering an osteogenic stimulator. The patient also received an order for a scooter.

The CERT reviewer requested additional documentation from the treating physician and received an attestation to his signature on the progress notes previously submitted. The submitted documentation did not support the documentation requirements in the National Coverage Determinations (NCD). This claim was scored as an insufficient documentation error and the Medicare Administration Contractor (MAC) recouped the payment for the osteogenic stimulator from the provider.

Resources

You can find more information on how to avoid errors on claims for osteogenic stimulators at the following sites.

- ✓ The Medicare National Coverage Determination for Osteogenic Stimulators (150.2) is available at <http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=65&ncdver=2&bc=AAAgAAAAAAAA%3d%3d&> on the CMS website. This contains the coverage requirements noted in this newsletter.
- ✓ Local Coverage Determinations and Local Coverage Articles are available at <http://www.cms.gov/Medicare/Coverage/DeterminationProcess/LCDs.html> on the CMS website.
- ✓ The “Medicare Claims Processing Manual,” Chapter 32, Section 110 (Coverage and Billing for Ultrasound Stimulation for Nonunion Fracture Healing) is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c32.pdf> on the CMS website. This manual section contains coverage requirements noted above as well as the billing and coding instructions for osteogenic stimulators.





Comprehensive Error Rate Testing (CERT): The 2 Midnight Rule and Elective Procedures

Provider Types Affected: Physicians and Hospitals

Background

Final Rule CMS-1599-F contains a provision, commonly known as the 2-Midnight Rule, which states that surgical procedures, diagnostic tests, and other treatments are generally appropriate for inpatient hospital admission and payment under Medicare Part A when the physician:

1. Expects the beneficiary to require a stay that crosses at least two midnights; and
2. Admits the beneficiary to the hospital based upon that expectation.

Probe and Educate Reviews

MACs and CMS clinicians have been conducting reviews of Medicare Part A hospital claims spanning less than 2 midnights, after formal inpatient admission, to determine compliance with CMS-1599-F. The focus of this article is to describe findings from those reviews as they pertain to admissions for elective procedures.

When the Expected Length of Stay was Less Than 2 Midnights

When a patient enters a hospital for a surgical procedure not specified by Medicare as inpatient only (i.e., inpatient only procedures under 42 Code of Federal Regulations (CFR) Section 419.22(n)), a diagnostic test, or any other treatment, and the physician expects to keep the patient in the hospital for less than 2 midnights, the services are generally inappropriate for inpatient admission and inpatient payment under Medicare Part A, regardless of the hour that the patient came to the hospital or whether the patient used a bed.

Where the medical record indicates that the physician did not or could not reasonably have expected to keep the patient in the hospital for 2 or more midnights, Medicare review contractors shall deny these claims unless the medical record contains documentation of an approved exception. To date, newly initiated mechanical ventilation (excluding anticipated intubations related to minor surgical procedures or other treatment) is the only approved exception.

When the Expected Length of Stay was 2 or More Midnights

In addition, there are cases in which the physician may expect the beneficiary to require a hospital stay spanning 2 or more midnights, but

What You Should Know

- ◆ Physicians do not need to include a separate attestation of the expected length of stay; rather, this information may be inferred from the physician's standard medical documentation, such as his or her plan of care, treatment orders, and physician's notes.

Helpful Links

The CMS-1599-F rule is available at <http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf> on the Internet.

an unforeseen circumstance results in a shorter length of stay. Examples of approved unforeseen circumstances include unexpected death, transfer to another hospital, departure against medical advice, clinical improvement, and election of hospice care in lieu of continued treatment in the hospital.

Failure to Document a 2 Midnight Expectation

The most common reason to deny a hospital claim spanning less than 2 midnights is the physician's failure to document a reasonable expectation that the beneficiary would require a hospital stay that would cross 2 or more midnights. Physicians do not need to include a separate attestation of the expected length of stay; rather, this information may be inferred from the physician's standard medical documentation, such as his or her plan of care, treatment orders, and physician's notes. Expectation of time and the determination of the underlying need for medical care at the hospital are supported by complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event, which are expected to be documented in the physician's assessment and plan of care.

Examples of Medicare Part A Inpatient Claims Denied

Example 1: Vascular Procedure, Documentation Did Not Support Inpatient Admission

A hospital submitted a claim for DRG 254 (Other Vascular Procedures w/o cc/mcc) for a 71-year-old beneficiary with intermittent claudication and renal artery stenosis. The beneficiary had a history of hyperlipidemia, hypertension, coronary artery disease and Type II Diabetes, and continued to smoke.

The beneficiary was scheduled for an elective (that is, nonemergency) abdominal aortogram, selective bilateral renal angiograms, selective bilateral iliac angiograms with run offs, and intravascular ultrasound. The procedure performed included stent placement to the left renal artery and to the right superficial femoral artery.

The beneficiary arrived at the hospital before 8 am on the morning of the scheduled procedure with an order to admit as an outpatient. The history and physical examination (from the preoperative office visit) that served as the admission note did not include any medical decision making beyond the name of the planned procedure and a recommendation to schedule a follow-up appointment in 6 weeks. There was no indication that the beneficiary would require hospital care that would cross 2 or more midnights.

The operative note indicated that the procedure was successful. There were no complications during the procedure or in the recovery room. The surgeon wrote postoperative orders that included "Admit to inpatient" just after noon on the day of the procedure. The only progress note on the chart was written on postoperative day #1. The beneficiary was up walking in the hallway and there was no hematoma or bleeding noted. A discharge order was written at noon on postoperative day #1. There was no discharge summary on the chart. The hospital stay crossed only 1 midnight.

The hospital claim for DRG 254 was denied because the documentation did not support a reasonable expectation that the beneficiary would require a hospital stay that would cross 2 or more midnights, nor was there documentation of an exception to the 2 Midnight Rule.

Example 2: Urologic Procedure

A hospital submitted a claim for DRG 728 (Inflammation of the male reproductive system w/o mcc) for a 69-year-old beneficiary with bladder stones and phimosis. The beneficiary had a history of hypertension, treated hypothyroidism and coronary artery disease. The beneficiary was scheduled for an elective (that is, nonemergency) cystoscopy, removal of bladder stones using a laser for lithotripsy, and a circumcision. The history and physical examination (from the preoperative office visit) that served as the admission note stated that the beneficiary had been evaluated by a cardiologist and medically cleared for the urologic surgery. There was no indication that the beneficiary would require hospital care that would cross 2 or more midnights.

The surgeon wrote an order “Admit to Short Stay Unit” just after 10 am on the morning of the procedure. The surgery began just after noon; there were several stones, which were successfully broken. All of the stone fragments were washed out of the bladder and the bladder wall appeared to be intact at the end of the procedure. Continuous bladder irrigation was started because there was some bleeding at the end of the procedure. The beneficiary was stable and in satisfactory condition when transferred to the recovery room. There were no problems noted in the recovery room. The surgeon’s postoperative orders stated “Observation status for bladder irrigation.” A progress note written on postoperative day #1 stated that the bladder catheter was removed, and the patient was comfortable and afebrile. In the afternoon on postoperative day #1, the surgeon wrote an order to “Discharge patient after he voids” and the patient went home shortly thereafter.

The hospital claim for DRG 728 was denied because there was no order for inpatient admission and the documentation did not support a reasonable expectation that the beneficiary would require a hospital stay that would cross 2 or more midnights, nor was there documentation of an approved exception to the 2 Midnight Rule.

Resources

- ✓ You can find more information on the 2 Midnight Rule at Inpatient Hospital Reviews, available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html> on the CMS website.
- ✓ The CMS-1599-F rule is available at <http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf> on the Internet.
- ✓ Frequently asked Questions about the 2 Midnight Rule are available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/Downloads/QAsforWebsitePosting_110413-v2-CLEAN.pdf on the CMS website.



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ICN 909177/ January 2015