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Medicare Quarterly Provider Compliance Newsletter

Guidance to Address Billing Errors

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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.

Comprehensive Error Rate Testing (CERT): Commodes

Provider Types Affected: Physicians, Non-physician Practitioners (NPPs) and Equipment (DME) Suppliers

Problem Description

Medicare covers Durable Medical Equipment (DME) as long as the equipment is medically necessary and a physician or Non-physician Practitioner (NPP) prescribes it for use in the beneficiary's home. The National Coverage Determination (NCD) for DME Reference List ([NCD 280.1](#)), although not an exhaustive list, provides categories of DME and coverage status.

The term DME is defined as equipment which:

- Can withstand repeated use; that is, could normally be rented and used by successive patients;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of illness or injury; and
- Is appropriate for use in a patient's home.

Commodes are covered by Medicare if the beneficiary is confined to bed or is "room confined." The term "room confined" means that the patient's condition is such that leaving the room is medically contraindicated. The accessibility of bathroom facilities generally would not be a factor in this determination. However, confinement of a patient to a home in a case where there are no toilet facilities in the home may be equated to room confinement. Moreover, payment may also be made if a patient's medical condition confines him to a floor of the home and there is no bathroom located on that floor.

Problem Description

The CERT program reports detailed results annually in the supplementary appendices. During the 2014 report period, the improper payment rate for Commodes/Bed Pans/Urinals was 94.7% with projected improper payments of approximately \$30 million.

Commodes: Frequently used Healthcare Common Procedure Coding System (HCPCS) codes for commodes are:

- E0163 - Commode chair, mobile or stationary, with fixed arms
- E0165 - Commode chair, mobile or stationary, with detachable arms

Medicare does not automatically assume payment for a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) item that was covered prior to a beneficiary becoming eligible for the Medicare Fee-for-Service (FFS) program. When a beneficiary receiving a DMEPOS item from another payer (including Medicare Advantage plans) becomes eligible for the Medicare FFS program, Medicare will pay for continued use of the DMEPOS item only if all Medicare coverage, coding and documentation requirements are met. Additional documentation to support that the item is reasonable and necessary may be required upon request of the DME Medicare Administrative Contractor (MAC).

Finding: Insufficient Documentation Causes Most Improper Payments

Most improper payments were due to insufficient documentation. Insufficient documentation means that something was missing from the medical records. Some examples are:

- All items billed to Medicare require a prescription.
- An order for each item billed must be signed and dated.
- For a commode to be covered by Medicare, a Detailed Written Order (DWO) must be received by the supplier before a claim is submitted. If the supplier bills for a commode without first receiving the completed DWO, it will be denied as not reasonable and necessary.
- The equipment must be provided by a supplier that is enrolled in Medicare.

Although someone other than the ordering physician may produce the DWO, the ordering physician or NPP must review the content and sign and date the document. The DWO must contain:

- The beneficiary's name;
- The physician's/NPP's name;
- Date of the order and the start date, if start date is different from the date of the order;
- Detailed description of the item(s): the detailed description in the written order may be either a narrative description or a brand name/model number;
- Physician/NPP signature and signature dated by the treating physician/practitioner, kept on file by the supplier, and made available upon request; signature and date stamps are not allowed; and
- The prescribing physician's/NPP's National Provider Identification (NPI).

For commode claims, documentation in the beneficiary's medical record must justify the medical need for a commode.

Examples of Improper Payments

Insufficient Documentation – No clinical records

A medical supply company billed for a commode (HCPCS E0163) for a date of service in November 2014. The documentation submitted, in response to an initial request for medical records, included a signed and dated order for a commode and proof of delivery.

The submitted documentation was missing medical records to support that the beneficiary is confined to bed or is “room confined.” There was no response to a request for additional documentation. As a result, the claim was scored as an insufficient documentation error and the MAC recouped payment for HCPCS E0163 from the medical supply company.

Insufficient Documentation – Missing documentation that the beneficiary is confined to bed or is “room confined.”

A medical supply company billed for a commode (HCPCS E0163) for a date of service in July 2014. The documentation submitted, in response to an initial request for medical records, included a signed and dated order for a commode, proof of delivery and clinical records.

The supplier submitted hospital records dated one week prior to the date of service documenting that the beneficiary had fallen and suffered rib fractures. The documentation did not indicate that the beneficiary is confined to bed or is “room confined.” The supplier also submitted a physician’s visit note dated one year after the date of service. Medical reviewers will generally consider medical records dated from 12 months prior to the date of service through 6 months after the date of service to support that the beneficiary is confined to bed or is “room confined.”

This claim was scored as an insufficient documentation error and the MAC recouped payment for HCPCS E0163 from the medical supply company.

Insufficient Documentation – Missing documentation that the beneficiary is confined to bed or is “room confined.”

A medical supply company billed for a commode (HCPCS E0163) for a date of service in February 2015. The documentation submitted, in response to an initial request for medical records, included a signed and dated

order for a commode and proof of delivery. The supplier also submitted a home safety checklist and progress notes that did not support that the beneficiary is confined to bed or is “room confined.”

In response to a request for additional documentation, the supplier submitted a progress note dated five months after the date of service which did not show necessity for the commode. Medical reviewers will generally consider medical records dated from 12 months prior the date of service through 6 months after the date of service to support that the beneficiary is confined to bed or is “room confined.”

This claim was scored as an insufficient documentation error and the MAC recouped payment for the E0163 from the medical supply company.

Resources

You can find more information on how to avoid errors on claims for Commodes in these resources:

- ✓ The National Coverage Determination for DME Reference List ([NCD 280.1](#));
- ✓ Local Coverage Determinations, for example, [L33736](#), and Articles, such as [A52461](#);
- ✓ “Medicare Claims Processing Manual,” [Chapter 20](#), “Medical Equipment, Prosthetics and Orthotics, and Supplies (DMEPOS);”
- ✓ MLN Matters® Article [MM8304](#) on Detailed Written Orders and Face-to-Face Encounters;
- ✓ Medicare Coverage of Durable Medical Equipment and Other Devices, [CMS Pub. 11045](#), September 2015; and
- ✓ [The Supplementary Appendices](#) for the Medicare Fee-for-Service 2014 Improper Payments Report.

Comprehensive Error Rate Testing (CERT): How to Avoid Errors on Claims for Manual Wheelchairs

Provider Types Affected: Physicians, Non-physician Practitioners (NPPs) and Durable Medical Equipment Suppliers

Background

As a condition for payment, Section 6407 of the Affordable Care Act requires a physician to document that the Physician, Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) has had a face-to-face encounter examination with a beneficiary in the six (6) months prior to the written order for certain items of Durable Medical Equipment (DME), including manual wheelchairs.

Mobility Assistive Equipment (MAE) is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their participation in Mobility-Related Activities of Daily Living (MRADLs), such as toileting, feeding, dressing, grooming, and bathing in customary locations within the home. Determination of the presence of a mobility deficit will be made by an algorithmic process, Clinical Criteria for MAE Coverage, to provide the appropriate MAE to correct the mobility deficit. Manual wheelchairs are covered if a physician or Non-Physician Practitioner (NPP) determines that the beneficiary has a mobility deficit and that the manual wheelchair is reasonable and necessary using the clinical criteria algorithm (See National Coverage Determination 280.3 B in the resources section below).

Problem Description

The CERT program reports detailed results annually in the supplementary appendices. During the 2014 report period, the improper payment rate for standard manual wheelchairs was 84.6% with projected improper payments of approximately \$170 million.

Wheelchairs:

Medicare covers several variations of manual wheelchairs. The Healthcare Common Procedure Coding System (HCPCS) codes for manual wheelchairs are as follows:

- K0001 Standard
- K0002 Standard hemi (low seat) wheelchair
- K0003 Lightweight wheelchair
- K0004 High strength, lightweight wheelchair
- K0005 Ultra lightweight wheelchair
- K0006 Heavy duty wheelchair
- K0007 Extra heavy duty wheelchair
- K0008 Custom manual wheelchair/base
- K0009 Other manual wheelchair/base

Finding: Insufficient Documentation Causes Most Improper Payments

Most improper payments for wheelchairs were due to insufficient documentation. Insufficient documentation means that something was missing from the medical records. Some examples are:

- All items billed to Medicare require a prescription.
- An order for each item billed must be signed and dated.
- For a manual wheelchair to be covered by Medicare, a detailed written order (DWO) must be received by the supplier before a claim is submitted. If the supplier bills for a wheelchair without first receiving the completed DWO, it will be denied as not reasonable and necessary.
- The equipment must be provided by a supplier that is enrolled in Medicare.

Although someone other than the ordering physician may produce the DWO, the ordering physician or NPP must review the content and sign and date the document. It must contain:

- The beneficiary's name;
- The physician's/NPP's name;
- Date of the order and the start date, if start date is different from the date of the order;
- Detailed description of the item(s): the detailed description in the written order may be either a narrative description or a brand name/model number;
- Physician/NPP signature and signature dated by the treating physician/practitioner, kept on file by the supplier, and made available upon request; signature and date stamps are not allowed, and
- The prescribing practitioner's National Provider Identification (NPI).

For wheelchair claims, documentation in the beneficiary's medical record must justify the medical need for a wheelchair.

General Coverage Criteria for Manual Wheelchairs

Coverage requirements for manual wheelchairs are described below in criteria A through G. A manual wheelchair and accessories for use inside the home (E1037 - E1039, E1161, K0001 - K0009) are covered if:

- Criteria A, B, C, D, and E are met; and
- Criterion F or G is met.

Criteria:

- A. The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more MRADLs such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:
1. Prevents the beneficiary from accomplishing an MRADL entirely; or
 2. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
 3. Prevents the beneficiary from completing an MRADL within a reasonable time frame.
- B. The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.
- C. The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.
- D. Use of a manual wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it on a regular basis in the home.
- E. The beneficiary has not expressed an unwillingness to use the manual wheelchair that is provided in the home.
- F. The beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
- G. The beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

Note: Physicians may use code G0454 (Physician documentation of face-to-face visit for Durable Medical Equipment determination performed by Nurse Practitioner, Physician Assistant or Clinical Nurse Specialist) for signing or co-signing the face-to-face encounter of the NP/PA/CNS. The physician should not bill the G code when he/she conducts the face-to-face encounter. Note that the G code may only be paid to the physician one time per beneficiary per encounter (paid based on Medicare Administrative Contractor (MAC) judgment), regardless of the number of covered items documented in the face-to-face encounter.

Examples of Improper Payments**Insufficient Documentation – No documentation of mobility limitation**

A medical supply company billed for a manual wheelchair (HCPCS K0001) for a date of service in January 2015. The documentation submitted in response to an initial request for medical records included a properly executed DWO with a date stamp indicating that the supplier received the DWO prior to delivery, a proof of delivery dated in June 2014, and a progress note dated in April. The progress note included documentation of the beneficiary's history and physical examination as follows: "musculoskeletal: 5/5 UE and LE bilaterally, denies dizziness, has mild dyspnea."

The submitted documentation was missing medical records to support that the beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more MRADLs and that cannot be resolved by the use of a cane or walker.

This claim was scored as an insufficient documentation error and the MAC recouped payment for the manual wheelchair from the medical supply company.

Insufficient Documentation – Missing a detailed written order

A medical supply company billed for a manual wheelchair (HCPCS K0001) for a date of service in February 2015. The documentation submitted in response to an initial request for medical records included: a verbal order which had been signed but not dated by the treating provider; proof of delivery dated in December 2014; an operative report dated in December 2014 that supported a diagnosis of ankle fracture; physical therapy notes; ankle X-ray reports; and laboratory results. There was no detailed written order for the standard wheelchair. The supplier sent duplicate records in response to an additional request for documentation. This claim was scored as an insufficient documentation error and the MAC recouped payment for the manual wheelchair from the medical supply company.

Insufficient Documentation – Missing documentation of a face-to-face encounter

A medical supply company billed for a manual wheelchair (HCPCS K0001) for a date of service in February 2015. The documentation submitted in response to an initial request for medical records included a properly executed DWO with a date stamp indicating that the supplier received the DWO prior to delivery, a proof of delivery dated in October 2014, an unsigned progress note dated in July 2014 showing that the beneficiary was using a cane, home assessment notes from October 2014, and physical therapy treatment notes from September through October 2014. There was no response to an additional request for documentation.

There was no documentation of a face-to-face examination to support that the beneficiary met the coverage criteria for manual wheelchairs (see criteria above). This claim was scored as an insufficient documentation error and the MAC recouped payment for the manual wheelchair from the medical supply company.

Resources

You can find more information on how to avoid errors on claims for Manual Wheelchairs at:

- ✓ The National Coverage Determination for DME Reference List ([NCD 280.3](#));
- ✓ Local Coverage Determinations, such as [L33788](#), and Articles, such as [A52497](#);
- ✓ MLN Matters® Article [MM8304](#) on Detailed Written Orders and Face-to-Face Encounters;
- ✓ “Medicare Claims Processing Manual,” Pub, 100-04, [Chapter 20](#), Durable Medical Equipment, Prosthetics and Orthotics, and Supplies (DMEPOS);
- ✓ Medicare Coverage of Durable Medical Equipment and Other Devices, [CMS Pub. 11045](#); and
- ✓ “[The Supplementary Appendices](#)” for the Medicare Fee-for-Service 2014 Improper Payments Report.

Comprehensive Error Rate Testing (CERT): Oxygen Equipment and Durable Medical Equipment Supplies

Provider Types Affected: Physicians, Non-physician Practitioners (NPPs) and Durable Medical Equipment Suppliers

Problem Description

The CERT program reports detailed results annually in “[The Supplementary Appendices](#).” During the 2014 report period, the improper payment rate for oxygen equipment and supplies was 62.1% with projected improper payments of approximately \$952 million. The Healthcare Common Procedure Coding System (HCPCS) codes for oxygen equipment and supplies include:

- E1390 - Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate.
- E0431 - Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing.

Finding: Insufficient Documentation Causes Most Improper Payments

Most improper payments were due to insufficient documentation. Insufficient documentation means that something was missing from the medical records, such as:

- All items billed to Medicare require a prescription.
- An order for each item billed must be signed and dated.
- For oxygen equipment and supplies to be covered by Medicare, a Detailed Written Order (DWO) must be received by the supplier before a claim is submitted. If the supplier bills for oxygen equipment and supplies without first receiving the completed DWO, it will be denied as not reasonable and necessary.
- The equipment must be provided by a supplier that is enrolled in Medicare.

Although someone other than the ordering physician may produce the DWO, the ordering physician or NPP must review the content and sign and date the document. It must contain:

- The beneficiary's name;
- The physician's/NPP's name;
- Date of the order and the start date, if start date is different from the date of the order;
- Detailed description of the item(s): the detailed description in the written order may be either a narrative description or a brand name/model number;
- Physician/NPP signature and signature dated by the treating physician/practitioner, kept on file by the supplier, and made available upon request; signature and date stamps are not allowed, and
- The prescribing practitioner's National Provider Identification (NPI).

For oxygen equipment and supplies claims, documentation in the beneficiary's medical record must justify the medical need for the oxygen equipment and supplies.

Examples of Improper Payments

Insufficient Documentation – Incomplete oxygen saturation results

A medical supply company billed for an oxygen concentrator and portable gaseous oxygen system (HCPCS E1390 and E0431) for a date of service in February 2015. The documentation submitted in response to an initial request for medical records included an initial Certificate of Medical Necessity (CMN) dated in June 2014; visit notes dated June 2014 documenting an oxygen saturation of 86% while walking and breathing room air; and proof of delivery dated in June 2014. The supplier sent duplicate records in response to an additional request for documentation.

The National Coverage Determination for Home Use of Oxygen ([NCD 240.2](#)) states that when a beneficiary has a condition for which oxygen therapy may be covered (see subsection D1 of the NCD), then coverage is available under one of three group categories.

Group I applies to this patient: Group I criteria includes patients with significant hypoxemia evidenced by blood gas values (or a measurement of arterial oxygen saturation obtained by ear or pulse oximetry) with an oxygen saturation at or below 88% during exercise for a patient who demonstrates an oxygen saturation at or above 89% during the day while at rest. For such a patient, supplemental oxygen is provided for use during exercise if there is evidence that the use of oxygen improves the hypoxemia that was demonstrated during exercise while breathing room air. (See [NCD 240.2](#) for other criteria.)

The submitted documentation was missing oxygen saturation results to support that oxygen improved the beneficiary's hypoxemia while exercising. As a result, the claim was scored as an insufficient documentation error and the Medicare Administrative Contractor (MAC) recouped payment for the oxygen concentrator and portable gaseous oxygen system from the medical supply company.

Insufficient Documentation – Missing the treating physician's evaluation within 30 days of the initial CMN

A medical supply company (provider specialty code 54) billed for an oxygen concentrator (E1390) for a date of service in February 2015. The documentation submitted in response to an initial request for medical records included: the initial CMN dated in June; proof of delivery dated in June 2014; and an oxygen saturation result dated in June 2014. In response to an additional request for documentation, the supplier sent progress notes from two months before the date of the CMN.

In certain situations for initial CMNs, according to the Local Coverage Determination, the blood gas study (or a measurement of arterial oxygen saturation obtained by ear or pulse oximetry) must be the most recent study obtained within 30 days prior to the date of the initial CMN and the beneficiary must be seen and evaluated by the treating physician within 30 days prior to the date of initial certification.

This claim was scored as an insufficient documentation error and the MAC recouped payment for the oxygen concentrator and portable gaseous oxygen system from the medical supply company.

Insufficient Documentation – Missing the treating physician's evaluation within 90 days prior to the date of the recertification CMN

A 'medical supply company with respiratory therapist' (provider specialty code A6) billed for an oxygen concentrator (E1390) for a date of service in February 2015. The documentation submitted in response to an initial request for medical records included an initial CMN; a recertification CMN; a proof of delivery dated in August 2014; a qualifying oximetry study from August 2014. In response to an additional request for documentation, the supplier sent two progress notes: one dated one month before the date of service and one dated one month after the date of service. The first progress note documented an acute episode of bronchitis and the second progress note documented a visit for sleep apnea.

For recertification following specific initial certification situations, according to the Local Coverage Determination, for beneficiaries initially meeting group I or II criteria, the beneficiary must be seen and re-evaluated by the treating physician within 90 days prior to the date of any recertification. If the physician visit is not obtained within the 90-day window but the beneficiary continues to use oxygen and the visit is obtained at a later date, coverage would resume beginning with the date of that visit.

If recertification is due, MACs do not pay the next month's claim if the test was not performed during the required time frame. If a qualifying test is not obtained between the 61st and 90th day of home oxygen therapy, but the patient continues to use oxygen and a test is obtained at a later date, MACs instruct suppliers to use the date of the repeat test as the date of service on a subsequent claim, and if that test meets Group II criteria, they resume payments from that point of time.

In this case, there was no documentation of a re-evaluation by the treating physician within 90 days prior to the date of the recertification CMN and the claim was scored as an insufficient documentation error and the MAC recouped payment for the oxygen concentrator from the medical supply company.

Resources

You can find more information on how to avoid errors on claims for Oxygen Equipment and Supplies in the following:

- ✓ National Coverage Determination Home Use of Oxygen ([NCD 240.2](#));
- ✓ Local Coverage Determinations, such as [L33797](#), and Articles, such as [A52514](#);

- ✓ “Medicare Claims Processing Manual,” [Chapter 20](#), Section 100.2.3 - Scheduling and Documenting Recertifications of Medical Necessity for Oxygen;
- ✓ MLN Matters® Article [MM8304](#) on Detailed Written Orders and Face-to-Face Encounters;
- ✓ Medicare Coverage of Durable Medical Equipment and Other Devices, [CMS Pub. 11045](#); and
- ✓ “[The Supplementary Appendices](#)” for the Medicare Fee-for-Service 2014 Improper Payments Report.

Comprehensive Error Rate Testing (CERT): Laparoscopic Hernia Repair

Provider Types Affected: Physicians

Problem Description

The CERT contractor conducted a special study of claims for laparoscopic hernia repairs submitted from July through September 2014. When CERT reviews a claim, all lines submitted on the claim undergo complex medical review. The long descriptions of Healthcare Common Procedure Coding System (HCPCS) codes for laparoscopic hernia repairs are:

- 49650 - Laparoscopy, surgical; repair initial inguinal hernia.
- 49652 - Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible.

Finding: Insufficient Documentation Caused Most of the Improper Payments

The vast majority of the improper payments were due to insufficient documentation. There were some claims with incorrect coding errors in the special study. Insufficient documentation means that something was missing from the medical records. For example, the medical record was missing one or more of the following:

- A signed operative report;
- The correct date of service; or
- A signature log or attestation for an illegible signature on a specific date of service.

Examples of Improper Payments

Insufficient Documentation – Missing Signature

A general surgeon billed for HCPCS 49652, for a laparoscopic repair of an umbilical hernia with mesh insertion. The submitted documentation included an unsigned operative report for the correct date of service for the billed procedure. The CERT reviewer requested a signature attestation for the unsigned operative report as well as additional documentation from the billing provider and received a hospital discharge summary dated one week prior to the date of surgery. The discharge summary documented that the beneficiary had been an inpatient investigated for abdominal pain and that umbilical hernia repair was scheduled for the following week. Although the discharge summary provided support for the medical necessity of the procedure, an unsigned operative report is insufficient to support this claim per Medicare guidelines. This claim was scored as an insufficient documentation error and the Medicare Administrative Contractor (MAC) recouped the payment from the provider.

Medicare requires providers of all services to sign their records. Providers should not add late signatures to the medical record, but instead may submit a signature attestation, such as the one available on the [CERT Provider website](#). Providers should also submit an attestation if signature(s) are not legible. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry, must be for a specific date of service, and must contain sufficient information to identify the beneficiary.

Insufficient Documentation – One Procedure Billed by Two Surgeons

A urologist billed for HCPCS 55866 (laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed) and for HCPCS 49650 with modifier 51 (multiple procedure), for an initial laparoscopic repair of an inguinal hernia. Modifier 51 is appropriate to use when multiple surgical procedures are performed at the same session by the same provider. Report the primary procedure (in this case, the prostatectomy) as listed without a modifier; report modifier 51 with the additional procedure.

The submitted documentation did not support that the billing physician performed an inguinal hernia repair on the billed date of service. The urologist's operative note indicated that during the performance of a laparoscopic prostatectomy, after the bladder was immobilized, a very large hernia and hernia sac was visualized and dissected. Once the prostatectomy was completed, a general surgeon came in to perform the inguinal hernia repair.

A review of Medicare billing records showed a paid claim for HCPCS 49651 (laparoscopy surgical repair recurrent hernia) for the general surgeon on the same date of service for the same beneficiary. The general surgeon's operative note documents that the beneficiary was undergoing a robotic prostatectomy by the urologist when the general surgeon was called into the operating room to evaluate a large inguinal hernia. It further documents that, once the prostatectomy was completed by the urologist, the hernia was repaired by the general surgeon. The trocar sites were then closed by the urologist. (Note that the general surgeon's claim was not sampled by CERT). This claim was scored as an insufficient documentation error and the MAC recouped the payment from the urologist for the laparoscopic inguinal hernia repair.

Note: Providers and their billing representatives must use caution when using modifier 51. It is inappropriate to use multiple procedure modifier 51 when there is no second procedure performed by the same surgeon.

Example of Improper Payments due to Incorrect Coding for Laparoscopic Hernia Repair

A general surgeon billed for HCPCS 49652, for a laparoscopic repair of an umbilical hernia with mesh insertion. The submitted operative note supports the incidental discovery of an incarcerated umbilical hernia while performing a laparoscopic appendectomy for gangrenous appendicitis with perforation. The operative report does not document the placement of mesh, but states that the hernia was closed "using the fascial closure device with 3 sutures and 0 Vicryl, this seemed to close nicely." The CERT medical reviewer recoded the claim from HCPCS 49652 to HCPCS 49653 for a laparoscopic repair of an incarcerated umbilical hernia. This claim was scored as an incorrect coding error and the MAC adjusted the payment.

Resources

You can find more information on how to avoid signature errors on claims at:

- "The Medicare Program Integrity Manual," [Chapter 3](#), Section 3.3.2.4.D - Signature Requirement, and Section 3.3.2.5 - Amendments, Corrections and Delayed Entries in Medical Documentation; and
- [The CERT Provider website](#) where you can find a signature attestation statement.

Recovery Auditor Finding: Monthly Capitation Payment (MCP) for End Stage Renal Disease (ESRD) Patients Receiving Four (4) or More Visits per Month

Provider Types Affected: Physicians and Non-physician Providers

Background

A Monthly Capitation Payment (MCP) is a monthly payment made to physicians for most dialysis-related physician services furnished to Medicare End Stage Renal Disease (ESRD) patients. Only one monthly payment is made for outpatient and/or center based ESRD patients receiving four or more face-to-face visits

per month. The monthly payment amount is based on the age of the beneficiary and the number of visits furnished during a calendar month.

The Current Procedural Terminology (CPT) codes 90951 - 90962 reflect these services and the CPT Code descriptions for CPT Codes 90951-90966 contain the term “per month” and are to be reported once per month.

Audit Findings

The Recovery Auditors conducted automated reviews of claims and identified claims with improper payments. In accordance with the “Medicare Claims Processing Manual,” [Chapter 8](#), Section 140, 140.1 and 140.4, the MCP for physicians or Non-Physician Practitioners (NPPs) rendering dialysis-related ESRD services to outpatient and/or center based patients receiving four or more face-to-face visits per month is payable only once per calendar month. This single payment includes all MCP services for the month. The claims in the review were improperly paid as they reflected payment for MCP services in excess of this limitation.

Guidance on how providers can avoid billing errors

Review the “Medicare Claims Processing Manual,” [Chapter 8](#), Sections 140, 140.1 and 140.4 for a better understanding of the MCPs. Key points include:

- Section 140: “Physicians and practitioners managing patients on dialysis (center based) are paid a Monthly Capitation Payment (MCP) for most outpatient dialysis-related physician services furnished to a Medicare End-Stage Renal Disease (ESRD) beneficiary. The payment amount varies based on the number of visits provided within each month and the age of the ESRD beneficiary. Physicians and practitioners managing ESRD patients who dialyze at home are paid a single monthly rate based on the age of the ESRD beneficiary, regardless of the number of face-to-face physician or practitioner visits. The MCP is reported once per month for services performed in an outpatient setting that are related to the patients’ ESRD.”
- Section 140.1: “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. The lowest payment amount applies when a physician provides one visit 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. The MCP is reported once per month for services performed in an outpatient setting that are related to the patients’ ESRD. 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.”
- Section 140.4: “Contractors must be able to identify dialysis patient history records and physicians who furnish services related to dialysis. In processing claims reimbursed under this method, contractors must assure that:
 - Only one monthly payment is made for any renal disease patient per month;
 - The payment amount is based on the age of the beneficiary and the number of visits furnished during a calendar month (center based patients);
 - Duplicate charges billed as a duplicate MCP or as separate charges for services covered by the monthly payment are denied;
 - Where several physicians or practitioners form a team to provide the monthly continuity of services to a group of patients, make only one monthly payment for each patient.”

Resources

You may find the following to be of assistance in billing for these services:

- ✓ “Medicare Claims Processing Manual,” [Chapter 8](#), Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claim, sections 140, 140.1, and 140.4: Monthly Capitation Payment Method for Physicians’ Services Furnished to Patients on Maintenance Dialysis;
- ✓ [The End-Stage Renal Disease \(ESRD\) Center webpage](#); and
- ✓ Medicare Learning Network® (MLN) Fact Sheet “[End-Stage Renal Disease Prospective Payment System](#)” (ICN 905143).

Recovery Auditor Finding: Admission Source for Inpatient Psychiatric Facilities

Provider Types Affected: Inpatient Psychiatric Hospitals (IPF)

Background

The Centers for Medicare & Medicaid Services (CMS) adjusts the Federal per diem base rate upward for the first day of a Medicare beneficiary’s Inpatient Psychiatric Hospitals (IPF) stay to account for the costs associated with maintaining a qualifying emergency department (ED). CMS makes this additional payment regardless of whether the beneficiary used ED services. However, the IPF should not receive the additional payment if the beneficiary was discharged from the acute care section of the same hospital. In that case, the costs of ED services are covered by the Medicare payment to the hospital for the immediately preceding acute care stay. (See [42 CFR Section 412.424\(d\)\(1\)\(v\)](#).) The Recovery Auditors reviewed claims for Diagnostic-Related Groups (DRGs) 001 - 999 for this study.

Audit Findings

The Recovery Auditors conducted automated reviews of IPFs and determined that providers are receiving additional payments on claims in which the patient was transferred from the Emergency Room to the IPF of the same facility. An IPF should not receive the additional payment if the beneficiary was discharged from the acute care section of the same hospital.

Guidance on how providers can avoid billing errors

Providers should review the instructions in the “Medicare Claims Processing Manual,” [Chapter 3](#), Inpatient Hospital Billing, Section 190.6.4.1, Source Code Admission for IPF PPS Claims for Payment of ED Adjustment, which states:

Source of admission code “D” is reported by IPFs to identify IPF patients who have been transferred to the IPF from the same acute care hospital or Critical Access Hospital (CAH). Claims with source of admission code “D” do not receive the ED adjustment.

Resources

You may find the following resources helpful in preparing these claims:

- ✓ The “Medicare Claims Processing Manual,” [Chapter 3](#), Inpatient Hospital Billing, Section 190.6.4.1, Source Code Admission for IPF PPS Claims for Payment of ED adjustment;
- ✓ MLN Matters® Article [MM3881](#) Source Code Admission ‘D’; and
- ✓ Medicare Learning Network® (MLN) Fact Sheet “[Inpatient Psychiatric Facility Prospective Payment System](#),” (ICN 006839).

Recovery Auditor Finding: Exact Duplicate Outpatient Claims

Provider Types Affected: All Outpatient Providers

Background

The Recovery Auditor conducted automated reviews to identify exact duplicate outpatient services billed on separate claims that may include but are not limited to the following criteria:

- Same HIC Number;
- Same Type of Bill;
- Same and different Provider Number;
- Same From Date of Service;
- Same Through Date of Service;
- Same Total Charges (on the line or on the bill); and
- Same HCPCS, CPT-4, or Procedure Code modifiers.

An overpayment exists when a provider bills and is paid for services that have been previously processed and paid.

Audit Findings

Claims in the review were found to be duplicates with duplicate payments made. The Medicare Administrative Contractors (MACs) were to recover the duplicate payments from the providers.

Guidance on how providers can avoid these billing errors

Providers should use correct modifiers to identify procedures that are not duplicate services. "Medicare Claims Processing Manual," [Chapter 4](#), Section 20.6, Use of Modifiers, discusses this process. But, if the procedures are not duplicates, then providers are reminded that they should submit the claim only once. If they need to determine the status of a claim, they should use the claim status inquiry process(es) available from their MAC.

Resources

You may find the following resources helpful in preparing these claims:

- ✓ "Medicare Claims Processing Manual," [Chapter 4](#), Section 20.6, Use of Modifiers, which is available on the Centers for Medicare & Medicaid Services (CMS) website.

Recovery Auditor Finding: Rituximab – units billed for non-covered/non-allowed services

Provider Types Affected: Physicians, Providers and Suppliers

Background

An overpayment exists when a provider bills for a service of J9310/Rituximab with an ICD-10 code that is not included in the list of covered ICD-10 codes for J9310/Rituximab with the applicable Local Coverage Determination documents. The Recovery Auditor conducted an automated review of claims for a service of J9310/Rituximab with the list of covered ICD-10 codes listed in the applicable Local Coverage Determination documents.

Audit Findings

In many claims, providers are billing for a service of J9310/Rituximab with an ICD-10 code that is not included in the list of covered ICD-10 codes in applicable Local Coverage Determination documents.

Guidance on how providers can avoid these billing errors

- Review the list of covered ICD-9 codes for J9310/Rituximab in the Local Coverage Determination [L35026](#) for your State and your Medicare Administrative Contractor (MAC) on the Centers for Medicare & Medicaid Services (CMS) website. The L35026 LCD shows the list of ICD-10 codes by MAC.
- Review the “Medicare Benefit Policy Manual,” [Chapter 15](#), about the reasonableness and necessity of drugs and biologics.

Resources

You may find the following resources helpful in preparing these claims:

- ✓ Local Coverage Determination [L35026](#); and
- ✓ “Medicare Benefit Policy Manual,” [Chapter 15](#).

Recovery Auditor Finding: Outpatient Cardiovascular Nuclear Medicine Correct Coding

Provider Types Affected: Outpatient Providers

Background

The Cardiovascular Nuclear Medicine services have coverage guidelines specific to the Local Coverage Determination and the Centers for Medicare & Medicaid Services (CMS) manuals. Decision-making for testing is based upon the presence of multiple clinical risk factors, the level of functional capacity, the risk of the surgery and the likelihood that the results of the cardiac testing would change the management. There are specific diagnoses associated with each form of testing. When an unapproved diagnosis is reported for any type of cardiovascular nuclear medicine service, the service is denied.

Audit Findings

The Recovery Auditor conducted an automated review of outpatient claims for cardiovascular nuclear medicine services. Here is a list of the affected Current Procedural Terminology (CPT) codes and descriptions in the review:

- 78451 Myocardial perfusion imaging, tomographic (SPECT); single study, at rest or stress
- 78452 Myocardial perfusion imaging, tomographic (SPECT); single study, at rest or stress and/or redistribution and/or rest reinjection
- 78453 Myocardial perfusion imaging, planar; single study, at rest or stress
- 78454 Myocardial perfusion imaging, planar; multiple studies, at rest and/or stress and/or redistribution and/or rest reinjection
- 78466 Myocardial imaging, infarct avid, planar; qualitative or quantitative
- 78468 Myocardial imaging, infarct avid, planar, w/ejection fraction by first pass technique
- 78469 Myocardial imaging, infarct avid, planar; tomographic (SPECT) w/ or w/o quantification
- 78472 Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress, wall motion

study plus ejection fraction, w/ or w/o additional quantitative processing

- 78473 Cardiac blood pool imaging, gated equilibrium; multiple studies, wall motion study plus ejection fraction, at rest & stress, w/ or w/o additional quantification
- 78481 Cardiac blood pool imaging (planar), first pass technique; single study, at rest or w/ stress, wall motion study plus ejection fraction, w/ or w/o quantification
- 78483 Cardiac blood pool imaging (planar), first pass technique; multiple studies, at rest & w/ stress, wall motion study plus ejection fraction, w/ or w/o quantification
- 78494 Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, w/ or w/o quantitative processing
- 78496 Cardiac blood pool imaging, gated equilibrium, single study, at rest, w/ rt ventricular ejection fraction by first pass technique
- 93015 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, cont ecg monitoring, &/or pharmacological stress; w/ super, interp & report
- 93016 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, cont ecg monitoring, &/or pharmacological stress; super only, w/o interp & report
- 93017 Cardiovascular stress test using maximal or submaximal, cont ecg monitoring, &/or pharmacological stress; tracing only, w/o interp & report
- 93018 Cardiovascular stress test using maximal or submaximal, cont ecg monitoring, &/or pharmacological stress; interp & report only fraction, w/ or w/o quantification

The automated review found claims containing billing with an unapproved diagnosis for cardiovascular nuclear medicine services.

Guidance on how providers can avoid these billing errors

- Review the CMS claims processing manuals listed in the resources section for guidelines on correct billing of these services.

Resources

You may find the following resources helpful in preparing these claims:

- ✓ “Medicare Claims Processing Manual,” [Chapter 23](#), Fee Schedule Administration and Coding Requirements: Section 10, ICD-10-CM Coding for Diagnostic Tests, available at on the CMS website.

Recovery Auditor Finding: Evaluation and Management (E/M) Coding in Skilled Nursing Facilities (SNFs)

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

Background

When evaluation and management (E/M) services are provided to patients in a Skilled Nursing Facility (SNF), CPT codes 99304-99318 should be reported. It is inappropriate to report hospital inpatient care codes (99221 - 99223, 99231-99233, 99238, and 99239) for SNF E/M services.

As described in the “Medicare Claims Processing Manual,” Chapter 12, Sections 30.6.13 and 30.6.14, E/M services provided to patients residing in a Skilled Nursing Facility (SNF) must be reported using the appropriate CPT level of service code within the range identified for initial nursing facility care (99304-99306) and subsequent nursing facility care (99307-99310). The annual nursing facility assessment is billed using CPT code 99318. SNF discharge services are billed using CPT codes 99315-99316. Inappropriate billing occurs when E/M services rendered in a SNF are billed with inpatient hospital E/M CPT .

Audit Findings

The Recovery Auditors are finding that physicians and Non-Physician Practitioners (NPPs) are reporting incorrect codes for E/M services provided to SNF Medicare patients. CMS reminds physicians and NPPs that they must not use CPT codes 99221- 99223, 99231-99233, 99238, and 99239, to bill for E/M services supplied to SNF patients. Those codes are for E/M services supplied to hospital patients.

Guidance on how providers can avoid these billing errors

- Review the CMS claims processing manuals listed in the resources section for guidelines on correct billing of these services.

Resources

You may find the following resources helpful in preparing these claims:

- ✓ “Medicare Claims Processing Manual,” [Chapter 12](#), Sections 30.6.13 and 30.6.14.



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