

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



Official Information Health Care
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Medicare Quarterly Provider Compliance Newsletter

Guidance to Address Billing Errors



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

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Archive of Previously-Issued Newsletters

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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.

Provider Types Affected legend:



Hospitals



Home Health
Agencies



Physicians



Radiation Therapy
Facilities



Non-Physician
Practitioners



Inpatient Hospitals



Qualified Health
Professionals



Clinical Laboratories

Comprehensive Error Rate Testing (CERT): End-Stage Renal Disease (ESRD) Related Services by a Physician or Other Qualified Health Care Professional, per Month

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Provider Types Affected: Physicians and Other Qualified Health Professionals

Background

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

- 90960 - ESRD related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
- 90961 - ESRD related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month

Approximately one third of the payments for ESRD related services were improper payments. The majority of the improper payments were due to insufficient documentation. The rest of the improper payments were due to incorrect coding or no documentation submitted. There were no claims with medical necessity errors in the special study.

Insufficient Documentation Causes Most Improper Payments

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

- No physician's signature on an order; or
- No documentation of the provider's face-to-face encounter(s).

Examples of Improper Payments for ESRD Services

Insufficient Documentation for ESRD Services

A nephrologist billed for HCPCS 90960 for the month of June 2013. The documentation submitted included inpatient progress notes for three dates in July during a one week span of time. Hemodialysis orders were submitted for those three dates. The CERT reviewer requested additional documentation from the treating physician and received an attestation to his signature on the progress notes previously submitted, but the documentation did not support the billed code which is for four or more face-to-face visits. This claim was scored as an insufficient

What You Should Know

- ◆ The majority of the improper payments were due to insufficient documentation. The rest of the improper payments were due to incorrect coding or no documentation submitted.

Helpful Links

The "Medicare Claims Processing Manual," [Chapter 8, Section 130 - Physicians and Supplier \(Nonfacility\) Billing for ESRD Services - General.](#)

documentation error and the Medicare Administrative Contractor (MAC) recouped the payment for the ESRD related services from the provider.

Insufficient Documentation for ESRD Services

A nephrologist billed for HCPCS 90960 for the month of June 2013. The submitted documentation included hemodialysis treatment notes dated 06/03/2013 through 06/28/2013 that were signed by the dialysis nurse. There was no clinical documentation to support face-to-face physician visits for this beneficiary during the month of June 2013; specifically, there was no documentation of assessment/examination or plan for the month of June 2013. The CERT reviewer requested additional documentation from the billing provider and received a signature attestation (see the CERT Provider Website for an example of a signature attestation <https://www.certprovider.com/>). This claim was scored as an insufficient documentation error and the MAC recouped the payment from the provider.

Incorrect Coding for ESRD Services

A nephrologist billed for HCPCS 90960 for the month of June 2013. The submitted documentation included one physician's note for date of service 06/10/2013, lab results, dialysis treatment notes for the month of June 2013, orders and visit rosters, which documented the dates of dialysis services (June 3, 7, 10, 14). However, there was no documentation of face-to-face encounters with the nephrologist other than the physician's note dated 06/10/2013. The CERT reviewer determined that the documentation supported a code change from 90960 to 90962 (ESRD related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month). This claim was scored as an incorrect coding error; the MAC adjusted the claim and recouped part of the payment from the provider.

No Documentation for ESRD Services

A nephrologist billed for HCPCS 90961 for the month of June 2013. No documentation was submitted in response to a request for the medical records. The CERT reviewer made a second request for documentation from the billing provider and received a note stating "this service was billed in error; please remove from patient's records. Refund will be sent." The claim was canceled two months after the date it was sampled by the CERT program. This claim was scored as a "no documentation" error because the CERT program measures improper payments even if providers voluntarily refund overpayments.

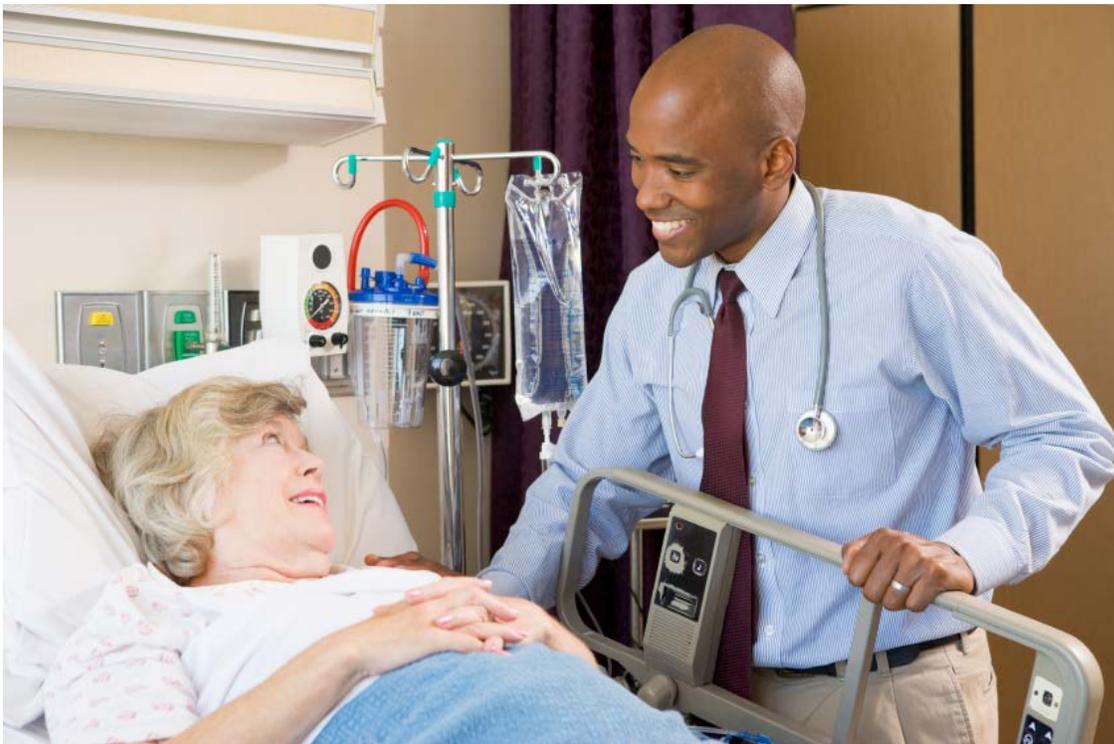
Resources

You can find more information on how to avoid errors on claims for ESRD services in:

- ✓ The "Medicare Claims Processing Manual," [Chapter 8, Section 130 - Physicians and Supplier \(Nonfacility\) Billing for ESRD Services - General](#);



- ✓ The “Medicare Claims Processing Manual,” [**Chapter 8, Section 140 - Monthly Capitation Payment Method for Physicians’ Services Furnished to Patients on Maintenance Dialysis;**](#)
- ✓ The “Medicare Benefit Policy Manual,” [**Chapter 11, End Stage Renal Disease;**](#)
- ✓ [**The End Stage Renal Disease \(ESRD\) Center**](#) on the CMS website; and
- ✓ The “[**End-Stage Renal Disease Prospective Payment System Fact Sheet**](#)” (ICN905143) on the CMS website.



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Comprehensive Error Rate Testing (CERT): Radiation Therapy Planning

Provider Types Affected: Hospitals and Radiation Therapy Facilities

Background

Radiation therapy is used to treat many types of tumors and may shrink tumors before a patient has surgery. Also, it may be used on tumors that cannot be removed with surgery, or can relieve symptoms caused by tumors. Providing radiation therapy requires careful planning and calculations.

CERT Study of Radiation Therapy Planning Claims

The CERT contractor conducted a special study of claims with lines for radiation therapy planning containing Healthcare Common Procedure Coding System (HCPCS) codes 77300 and 77301, submitted from October through December 2013. When CERT reviews a claim, they conduct complex medical review on all lines submitted on the claim. The long descriptions of these HCPCS codes are:

- 77300 - Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician
- 77301 - Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications

Intensity Modulated Radiotherapy (IMRT) delivers a more precise radiation dose to a solid tumor while sparing the surrounding normal tissues by using non-uniform radiation beam intensities that are determined by various computer-based optimization techniques. IMRT is considered reasonable and necessary in instances where sparing the surrounding normal tissue is essential and the patient has met all the conditions for IMRT as defined in the applicable coverage policy. IMRT is an evolving technology and, as such, IMRT Local Coverage Determinations are reviewed and updated as often as necessary.

The IMRT plan (77301) is a separate and distinct step in the process of care whose product is the computerized plan developed by the physician, radiation physicist, and dosimetrist; and is required for the delivery of IMRT.

What You Should Know

- ◆ When CERT reviews a claim, they conduct complex medical review on all lines submitted on the claim.

Helpful Links

"Medicare Program Integrity Manual," [Chapter 3, Section 3.3.2.4.D - Signature Requirement.](#)

The CERT study found that the improper payment rate for these services was significantly higher than the rate for many other physician specialty services.

Insufficient Documentation Caused All of the Improper Payments

All of the improper payments were due to insufficient documentation. There were no claims with medical necessity errors or 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:

- No radiation therapy plan was submitted;
- The documentation submitted did not adequately describe the service defined by the HCPCS code;
- The correct date of service;
- A physician's signature; and/or
- A signature log or attestation for an illegible signature.

Examples of Improper Payments due to Insufficient Documentation for Radiation Therapy Planning

Insufficient Documentation – Missing Signatures

A radiation oncologist billed for HCPCS 77301 and 77300, and for multi-leaf collimator devices for IMRT, therapeutic radiology simulation-aided field setting, therapeutic radiology treatment planning (complex), and IMRT treatment delivery for three dates of service. The submitted documentation included notes for three dates of service different from those billed, an unsigned and undated treatment plan, an undated histogram, a Computed Tomography (CT) scan report, an unsigned fine needle aspiration report, an unsigned operative report, and a breast Magnetic Resonance Imaging (MRI) report. There was no documentation of complex treatment devices (irregular blocks, special shields, compensators, wedges, molds, or cast), and there was no verification of treatment setup and delivery. No signature attestation statement was received from either the radiation oncologist or the radiation physicist and no other medical records were submitted despite a request for additional documentation. This claim was scored as an insufficient documentation error.

Insufficient Documentation – Missing Order, Intent to Order, and Dosimetry Calculation

A radiation oncologist billed for HCPCS 77301; the documentation received included CT images, a cumulative dose volume histogram, a treatment plan report, and an unsigned IMRT plan summary/calculation for the date of service billed. The billing provider did not submit an authenticated copy of the treating physician's progress notes to document the order/intent to order radiation therapy prior to billed date of service, nor did the billing provider submit an authenticated copy of the dosimetry calculation for date of service. No other medical records were submitted despite a request for additional documentation. This claim was scored as an insufficient documentation error.

Insufficient Documentation – Missing Treatment Notes

A radiation oncologist billed for HCPCS 77300 Basic radiation dosimetry calculation (9 units of service) on a date of service in November 2013. The documentation received included a letter written to CERT and dated around the time of the request for documentation. However, CERT applies the relevant sections of the “Program Integrity Manual” to letters from providers; such letters often attest to information missing from the medical record. (See Note below). There was no documentation from the medical record showing that basic radiation dosimetry calculation (9 units of service) was performed on the billed date of service. The submitted documentation also included a visit note dated in October 2013, a simulation record, treatment planning note, unsigned plan summary sheet, and unsigned calculations all dated prior to the date of service. There were also two visit notes with dates after the billed date of service. After an additional request for documentation, a signature attestation statement (see the CERT Provider Website (<https://www.certprovider.com/>) for an example of a signature attestation) was received from the radiation oncologist for the billed date of service, but there was no medical record for the billed date of service. Additional notes including a physician’s consultation were received for several dates other than the billed date of service. This claim was scored as an insufficient documentation error.

Note: Guidelines Regarding Which Documents Review Contractors Will Consider-

Supplier prepared statements and physician attestations by themselves do not provide sufficient documentation of medical necessity, even if signed by the ordering physician.

Resources

You can find more information on how to avoid errors on claims for Radiation Therapy Services at:

- ✓ The “Medicare Claims Processing Manual,” [Chapter 4, Section 200.3 Billing Codes for Intensity Modulated Radiation Therapy \(IMRT\) and Stereotactic Radiosurgery \(SRS\)](#);
- ✓ The “Medicare Claims Processing Manual,” [Chapter 12, Section 70 Payment Conditions for Radiology Services](#);
- ✓ The “Medicare Claims Processing Manual,” [Chapter 13, Section 70 Radiation Oncology - Therapeutic Radiology](#); and
- ✓ The “Medicare Program Integrity Manual,” [Chapter 3](#), Section 3.3.2.1.1 B. Guidelines Regarding Which Documents Review Contractors Will Consider, Section 3.3.2.4.D - Signature Requirement, Section 3.3.2.5 - Amendments, Corrections and Delayed Entries in Medical Documentation.



Comprehensive Error Rate Testing (CERT): Transcatheter Aortic Valve Replacement/Implantation (TAVR/TAVI)

Provider Types Affected: Physicians and Hospitals

Background

Patients who have severely obstructed blood flow from the heart to the body may need aortic valve replacement. For some patients, this type of open-heart surgery is too risky and they are considered “inoperable.” These patients may benefit from surgery performed by threading a special valve device through an artery to reach the heart without performing open-heart surgery and without requiring a heart-lung machine. This type of surgery is called “transcatheter” surgery and can be performed through the leg (that is, the transfemoral approach through the femoral artery), through the lower tip of the heart (that is, the transapical approach), or through the large artery which carries oxygenated blood away from the heart (the transaortic approach).

Medicare National Coverage Determination (NCD) 20.32 allows coverage for Transcatheter Aortic Valve Replacement (TAVR) when performed with a Food and Drug Administration (FDA)-approved device according to FDA labeled indications and specific requirements. NCD 20.32 sets out detailed conditions for coverage and specifies characteristics of the hospital facility performing the procedure. TAVR/TAVI is also covered for uses that are not expressly listed as FDA-approved indications when performed within a clinical study that fulfills all of the requirements in NCD 20.32.

CERT Study of TAVR/TAVI Services

CERT conducted a special study of TAVR/TAVI services for Part B claims submitted from July through September 2013. The Healthcare Common Procedure Coding System (HCPCS) codes for the studied TAVR/TAVI services are listed below:

- 33361 - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach
- 33362 - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach
- 33365 - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (e.g., median sternotomy, mediastinotomy)

What You Should Know

- ◆ Surgery performed by threading a special valve device through an artery to reach the heart without performing open-heart surgery and without requiring a heart-lung machine is called “transcatheter” surgery.

Helpful Links

[National Coverage Determinations \(NCD\) 20.32.](#)

Approximately one third of the payments for TAVR/TAVI services were improper payments. The vast majority of the improper payments were due to insufficient documentation. There were no claims with medical necessity errors in the special study.

Insufficient Documentation Causes Most Improper Payments

Insufficient documentation means that something was missing from the medical records. For example, the medical record was missing one or more of the following:

- Pre-operative evaluation(s);
- Operative note;
- A physician's signature; and/or
- A signature log or attestation for an illegible signature.

Notes About Modifiers

Modifier 62 is appropriate when two surgeons work together as primary surgeons performing distinct part(s) of a procedure; each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s)) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added.

Modifier Q0 indicates an investigational clinical service provided in a clinical research study that is in an approved clinical research study.

Examples of Improper Payments for TAVR/TAVI Services

Insufficient Documentation for TAVR Services

A thoracic surgeon billed for HCPCS 33361 (TAVR/TAVI with prosthetic valve; percutaneous femoral artery approach) with modifiers 62 and Q0 (see note below) for a date of service in July 2013. The submitted documentation included the operative note and one post-operative note. The CERT reviewer checked and confirmed the facility's registration on the Centers for Medicare & Medicaid Services (CMS) TAVR registry.

This procedure was performed for treatment of symptomatic aortic valve stenosis according to an FDA-approved indication. Therefore, according to the NCD, two cardiac surgeons must have independently examined the patient face-to-face and evaluated the patient's suitability for open Aortic Valve Replacement (AVR) surgery; both surgeons must have documented the rationale for their clinical judgment. However, there was no documentation of preoperative face-to-face evaluations with the cardiovascular surgeon or the interventional cardiologist. This claim was scored as an insufficient documentation error and the MAC recouped the payment from the provider.

Insufficient Documentation for TAVR Services

A cardiac surgeon billed for HCPCS 33361 (TAVR/TAVI with prosthetic valve; percutaneous femoral artery approach) with modifier 62 for a date of service in August 2013. The submitted documentation included an unsigned operative note. The CERT reviewer requested additional documentation and received a duplicate unsigned operative note, an unsigned intra-operative echocardiogram report and an undated unsigned dictated preoperative visit note (which stated “final recommendations will follow”).

This procedure was performed for treatment of symptomatic aortic valve stenosis according to an FDA-approved indication. Therefore, according to the NCD, two cardiac surgeons must have independently examined the patient face-to-face and evaluated the patient's suitability for open AVR surgery; both surgeons must have documented the rationale for their clinical judgment. However, there was only one preoperative face-to-face evaluation submitted and it was unauthenticated. This claim was scored as an insufficient documentation error and the MAC recouped the payment from the provider.

Incorrect Coding for TAVR Services

An interventional cardiologist billed for HCPCS 33362 (TAVR/TAVI with prosthetic valve; open femoral artery approach) with modifiers 62 and Q0 for a date of service in July 2013. The submitted documentation included an operative report for the billed date of service, which documented TAVR using an open axillary artery approach. The cardiologist also submitted a transesophageal echocardiography report and in-patient hospital notes.

The CERT reviewer requested additional documentation from the billing provider and received hospital records for the day of surgery and an office visit note dated in May 2013 that included the statement, “I recommend that he start evaluation for a TAVR program.” The CERT reviewer also confirmed that the procedure was performed in a CMS approved clinical research study. The documentation supported a code change to HCPCS 33363. This claim was scored as an incorrect coding error and the MAC adjusted the claim.

Incorrect Coding for TAVR Services

An interventional cardiologist billed for HCPCS 33361 (TAVR/TAVI with prosthetic valve; percutaneous femoral artery approach) with modifier 62 for a date of service in June 2013. The submitted documentation included an operative report showing transapical approach through left thoracotomy.

The CERT reviewer requested additional documentation and received preoperative consultation notes from two cardiac surgeons dated within a few weeks of the procedure. The notes provided support for medical necessity and the treatment plan. The documentation supported a code change to 0318T (implantation of catheter-delivered prosthetic aortic heart valve, open thoracic approach, (transapical, other than transaortic)). This claim was scored as an incorrect coding error and the MAC adjusted the claim.

NOTE: Beginning January 1, 2014, temporary code 0318T above is retired. TAVR claims with dates of service on and after January 1, 2014, must instead use permanent code 33366.

No Documentation for TAVR Services

An internal medicine specialist billed for HCPCS 33365 with modifier 62 for a date of service in the first week of September 2013. In response to the initial request for documentation, a note was received which stated, "We regret to inform you that we are unable to process your request as the patient did not receive services on the service dates requested." An additional request for documentation resulted in a note that stated "Request needs to be sent to hospital for documentation on need;" however, it is the billing provider (in this case, the physician) who is responsible for providing documentation to support services billed. No documentation was received to support this billed service. This claim was scored as a "no documentation" error and the MAC recouped the payment from the provider.

Resources

You can find more information on how to avoid errors on claims for TAVR/TAVI services in:

- ✓ [National Coverage Determinations \(NCD\) 20.32](#) on the CMS website;
- ✓ [Coverage with Evidence Development: Clinical Study Approvals](#) on the CMS website; and
- ✓ The "Medicare Claims Processing Manual," [Chapter 32 - Billing Requirements for Special Services, Section 290 - Transcatheter Aortic Valve Replacement \(TAVR\)](#).



Comprehensive Error Rate Testing (CERT): Unlisted Chemistry Procedures

Provider Types Affected: Clinical Laboratories

Background

The CERT contractor conducted a special study of Healthcare Common Procedure Coding System (HCPCS) code 84999, unlisted chemistry procedure Part B claims submitted from October through December 2013.

Procedures or services that do not have a specific HCPCS code may be identified by the appropriate “Unlisted procedure” code. If the procedure or service is rarely provided, unusual, variable, or new, a special report may be necessary. The special report should include pertinent information such as a definition or description of the nature, extent, and need for the procedure; and the time, effort, and equipment necessary to provide the service.

Insufficient Documentation Causes Most Improper Payments

Most improper payments were due to insufficient documentation. There were no claims with medical necessity errors in the special study.

Insufficient documentation means that something was missing from the medical records. For example, the medical record was missing for one or more of the following:

- Laboratory results;
- The correct date of service;
- Medical records documenting the reason for performing the test;
- Medical records documenting intent to order the test;
- A physician’s signature; and/or
- A signature log or attestation for an illegible signature.



What You Should Know

- ◆ The special report should include pertinent information such as a definition or description of the nature, extent, and need for the procedure; and the time, effort, and equipment necessary to provide the service.

Helpful Links

Medicare Claims Processing Manual, [Pub. 100-4, Chapter 16, Section 100.4 \(Not Otherwise Classified Clinical Laboratory Tests\)](#).

Examples of Improper Payments due to Insufficient Documentation for an Unlisted Chemistry Procedure

Insufficient Documentation – Incorrect Date of Service

An independent laboratory billed for one unit of service for HCPCS 84999 for a date of service in late September 2013. The submitted documentation included orders for laboratory tests and a pathology report both dated in August 2013, Cancer TYPE ID results dated in mid-September 2013, and physician notes that supported medical necessity due to a diagnosis of Breast Cancer. Therefore, the date of service was neither the date of collection nor the date the test was performed. The CERT reviewer requested additional documentation and received duplicates of the previously submitted records. This claim was scored as an insufficient documentation error and the MAC recouped the payment from the provider.

Insufficient Documentation – Missing Complete Results

An independent laboratory billed for one unit of service for HCPCS 84999. The test was described as an analysis of the quantitative activity of multiple genes on a sample of breast cancer tissue. The submitted documentation included a single quantitative gene activity report, a pathology report of left breast tissue, a requisition/order form, other lab results, and a progress note which documented that gene analysis testing results placed the patient in a low risk category with a low risk of recurrence. Physician office notes supported medical necessity due to a diagnosis of breast cancer. This claim was scored as an insufficient documentation error and the MAC recouped part of the payment from the provider.

Insufficient Documentation – Missing Order and Missing Intent to Order

An independent laboratory billed for one unit of service for HCPCS 84999. The submitted documentation included an unsigned requisition and results of the specialized test. No other medical records were submitted despite a request for additional documentation. In the event that an order/requisition for a laboratory test is unsigned, CERT will accept signed and dated clinical records documenting the intent to order the test. This claim was scored as an insufficient documentation error and the MAC recouped the payment from the provider.



Resources

You can find more information on how to avoid errors on claims for Unlisted Chemistry Procedures and Laboratory Tests at:

- ✓ The “Medicare Claims Processing Manual,” [Chapter 16, Section 40.8 \(Date of Service \(DOS\) for Clinical Laboratory and Pathology Specimens\)](#), which states that the date of service for clinical laboratory and pathology specimens must be the date the specimen was collected;
- ✓ The “Medicare Claims Processing Manual,” [Chapter 16, Section 100.4 \(Not Otherwise Classified Clinical Laboratory Tests\)](#);
- ✓ The “Medicare Benefit Policy Manual,” [Chapter 15, Section 80.6 \(Requirements for Ordering and Following Orders for Diagnostic Test\)](#), which states that “While a physician order is not required to be signed, the physician must clearly document, in the medical record, his or her intent that the test be performed”; and
- ✓ You may also wish to review [MLN Matters® Article MM6018](#) (Date of Service (DOS) for Clinical Laboratory and Pathology Specimens).





Recovery Auditor Finding: Cardiovascular Nuclear Medicine

Providers Types Affected: Physicians/Non-physician Practitioners

Problem Description

Potential incorrect billing occurred for claims billed with ICD-9-CM codes that are not listed in Local Coverage Determinations (LCDs) as medically necessary.

Background

The Recovery Auditor conducted automated reviews of claims for codes that support medical necessity of Cardiovascular Nuclear Medicine procedure codes. MACs Local Coverage Determinations include comprehensive lists of ICD-9-CM codes that support medical necessity for Cardiovascular Nuclear Medicine procedure codes.

Finding

Potential incorrect billing occurred for claims billed with ICD-9-CM codes that do not support medical necessity.

Guidance to Provider to Avoid Coding Errors

- ✓ Physicians are encouraged to review the lists of codes that support medical necessity for Cardiovascular Nuclear Medicine procedure codes. These may be found in the LCD of your MAC, available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx> on the Centers for Medicare & Medicaid Services website. Once at that site, follow the instructions for searching for the LCD that is appropriate for you and your MAC.

What You Should Know

- ◆ Potential incorrect billing occurred for claims billed with ICD-9-CM codes that do not support medical necessity.

Helpful

Title XVIII of the Social Security Act (SSA): [Section 1833\(e\)](#).

Resources

Providers may review the following to assist in correct coding of these claims:

- ✓ Title XVIII of the Social Security Act (SSA): [Section 1862\(a\)\(1\)\(A\)](#);
- ✓ Title XVIII of the Social Security Act (SSA): [Section 1833\(e\)](#);
- ✓ The “Medicare National Coverage Determinations (NCD) Manual,” [Chapter 1, Part 4: 220.8 - Nuclear Radiology Procedure 220.12 - Single Photon Emission Computed Tomograph \(SPECT\)](#); and
- ✓ The “Medicare Claims Processing Manual,” [Chapter 13, Sections 20 - Payment Conditions for Radiology Services, 50 - Nuclear Medicine \(CPT 78000 - 79999\), 50.1 - Payments for Radionuclides, and 50.2 – Stressing Agents](#).





Recovery Auditor Finding: Post Acute Transfer

Provider Types Affected: Inpatient Hospitals

Problem Description

The Recovery Auditor conducted an automated review of claims to identify any patient discharge status codes improperly reported under Medicare's Inpatient Prospective Payment System (IPPS) Transfer Policy. This policy applies to all Diagnosis-Related Groups (DRGs) using the patient discharge status code 02, and specified DRGs using patient discharge status codes 03, 05, 06, 62, 63, and 65. Under the transfer policy, the initial acute care facility is paid a per diem rate (up to the full DRG) and the receiving facility is paid the full DRG payment. Claims reported as discharge status 01 (to home) rather than as a transfer or claims reported as a transfer reported incorrectly would result in improper payment.

Discharge status codes include:

- 02 - Discharged/transferred to a short term general hospital for inpatient care;
- 03 - Discharged/transferred to Skilled Nursing Facility (SNF) with Medicare certification in anticipation of covered skilled care;
- 05 - Discharged/transferred to designated cancer center or children's hospital;
- 06 - Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care;
- 62 - Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital;
- 63 - Discharged/transferred to Long Term Care Hospital (LTCH); and
- 65 - Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.



What You Should Know

◆ This policy applies to all Diagnosis-Related Groups (DRGs) using the patient discharge status code 02, and specified DRGs using patient discharge status codes 03, 05, 06, 62, 63, and 65.

Helpful Links

The "Medicare Claims Processing Manual," [Chapter 3 – Inpatient Hospital Billing](#).

Finding

Analysis of discharge status codes and secondary claim data identified improper payments.

Guidance for Providers to Avoid Errors

- ✓ Hospitals are urged to review [MLN Matters® Number SE0801, Clarification of Patient Discharge Status Codes and Hospital Transfer Policies](#), which helps you determine the right discharge status code to use with your claims.

Resources

Providers may review the following to assist in avoiding this problem issue:

- ✓ The “Medicare Claims Processing Manual,” [Chapter 3 – Inpatient Hospital Billing](#);
- ✓ OIG Report A-06-93-00095 “[Medicare Hospital Patient Transfers Improperly Reported and Paid as Hospital Discharges](#)”;
- ✓ OIG Report A-04-04-03000 “[Review of Hospital Compliance with Medicare’s Postacute Care Transfer Policy during Fiscal Years 2001 and 2002](#)”;
- ✓ [42 CFR 412.4](#); and
- ✓ The “Medicare Claims Processing Manual,” [Chapter 25 – Completing and Processing the Form CMS-1450 Data Set \(Rev. 2250, 07-01-11\)](#).

Recovery Auditor Finding: Validation of Late Episode Timing

Provider Types Affected: Home Health Agencies

Problem Description

Late episode home health claims not appropriately adjusted by Medicare will be validated and recoded. Service is incorrectly coded (non Diagnosis Related Group (DRG) and there is no evidence to support another error code.

Background

Under the refined Home Health Prospective Payment System (HH PPS) case-mix system, HH episodes are paid differently based on whether the episode is classified as 'early' or 'later.' The first two episodes of a sequence of adjacent episodes are considered 'early.' The third episode of that sequence and any subsequent episodes are considered 'later.' Claims for HH PPS episodes indicate whether the provider believes the episode is early or later using the first position of the HH PPS code. Codes beginning with 1 or 2 represent early episodes. Codes beginning with 3 or 4 represent later episodes.

Finding

The Recovery Auditor reviewer determined that the medical service, treatment, and/or equipment was medically necessary and that such service, treatment, and/or equipment was provided at a proper level of care, but billed and paid based on a code that was not accurately reflected in the documentation provided. The only issue is the appropriate code selection.

Based on the review of the treatment authorization number and actual therapy visits provided, home health claims determined to be late episodes (the 3rd episode and beyond in a sequence of adjacent covered episodes) were paid incorrectly by Medicare. The payment was not appropriately adjusted for episode timing, clinical domain, functional domain, therapy utilization, or a combination of any of these factors, causing inappropriate payments.

Errors or patterns of over-utilization were found on the part of the provider or supplier in inappropriate code selection.

What You Should Know

- ◆ HH episodes are paid differently based on whether the episode is classified as 'early' or 'later.' The first two episodes of a sequence of adjacent episodes are considered 'early.' The third episode of that sequence and any subsequent episodes are considered 'later.'

Helpful Links

The "Medicare Claims Processing Manual," [Chapter 10, Section 10.1.19.2](#) contains the manual instructions for Home Health Agency Billing.

Guidance for Providers to Avoid Errors

Home Health Agencies should review the following documents for a better understanding of documenting ‘early’ and ‘late’ episodes of care:

- ✓ [“Quick Reference Information: Home Health Services”](#) (ICN 908504 January 2014); and
- ✓ MLN Matters® Number: [MM6027 Correction to Determinations of Early Episodes versus Later Episodes under the Home Health Prospective Payment System \(HH PPS\)](#).

Resource

The following resource also helps explain this issue:

- ✓ The “Medicare Claims Processing Manual,” [Chapter 10, Section 10.1.19.2 contains the manual instructions for Home Health Agency Billing](#).





Recovery Auditor Finding: Nerve Conduction Studies (NCS) – Maximum Units

Provider Types Affected: Physician/Non-physician Practitioners

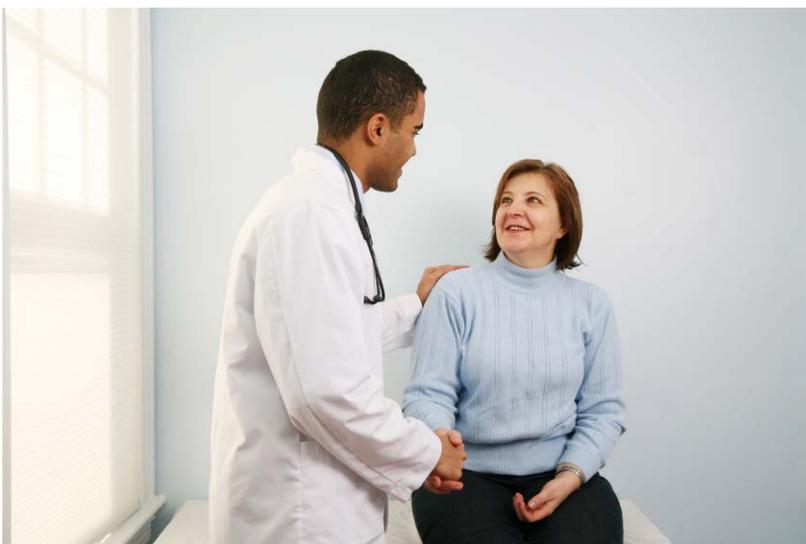
Problem Description

Potential incorrect billing occurred for claims reporting CPT codes 95900 and 95904 for units in excess of what is medically necessary per utilization guidelines.

Background

The Recovery Auditor conducted automated reviews to identify incorrect billing for these codes. Medicare will pay only once for Nerve Conduction Studies (NCS) per nerve, or named branch of a nerve, regardless of the number of sites tested or the number of methods used on that nerve. For instance, testing the ulnar nerve at wrist, forearm, below elbow, above elbow, axilla and supraclavicular regions will all be considered as a single nerve. The descriptors for the related CPT codes are:

- CPT 95900 - Nerve Conduction, Amplitude and Latency/Velocity Study, each nerve; motor, without F-Wave Study.
- CPT 95904 - Nerve Conduction, Amplitude and Latency/Velocity Study, each nerve, sensory.



What You Should Know

- ♦ Medicare will pay only once for NCS per nerve, or named branch of a nerve, regardless of the number of sites tested or the number of methods used on that nerve.

Helpful Links

LCDs are available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx> on the CMS website.

Finding

Potential incorrect billing occurred for claims billed with units in excess of the maximum threshold.

Guidance to Providers to Avoid Errors

- ✓ Review current Local Coverage Determinations provided by your MAC and ensure that you bill up to the maximum numbers of units allowed per nerve. LCDs are available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx> on the CMS website. Once at that site, follow the instructions to find the LCD appropriate for you and your MAC.

Resources

Other resources that assist providers in proper billing on this issue are:

- ✓ Title XVIII of the Social Security Act (SSA): [Section 1862\(a\)\(1\)\(A\)](#); and
- ✓ Title XVIII of the Social Security Act (SSA): [Section 1833\(e\)](#).





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