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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): Coudé Tip Catheters

Provider Types Affected: Durable Medical Equipment

Background

The CERT program analyzes data on reviewed claims throughout the report period and periodically ranks the sampled claims in error according to the claim type. A recent analysis of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claims showed that some claims for coudé tip catheters had high sample dollars in error.

A Coudé (curved) tip catheter is a special type of urinary catheter often used in cases where urethral catheterization is difficult. The most common reasons for difficult urethral catheterization are urethral strictures and bladder neck contractures. Other reasons for difficult urethral catheterization include, for example, benign prostatic hyperplasia, false passages, phimosis, meatal stenosis, and prostate cancer.

Urinary catheters come in many sizes, materials (for example, latex, silicone, Teflon™), and types (for example, Foley, straight, coudé tip). Urinary catheters may be inserted to drain the bladder intermittently or may remain in the bladder for prolonged periods of time (that is, indwelling catheters).

The Healthcare Common Procedure Coding System (HCPCS) code for these catheters is A4352. The long description for HCPCS code A4352 is - Intermittent urinary catheter; coudé (curved) tip, with or without coating (Teflon™, silicone, silicone elastomeric, or hydrophilic, etc.), each.

Urinary catheters drain urine from the bladder. Some reasons for using urinary catheters include:

- Urinary retention (inability to empty the bladder);
- Surgery on the prostate or genitals; and
- Other medical conditions such as multiple sclerosis or spinal cord injury.

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. For claims for urinary catheters, documentation in the beneficiary's medical record must justify the medical need for a urinary catheter and the particular type of catheter must be necessary for the beneficiary.

Urinary catheters and external urinary collection devices are covered to drain or collect urine for a beneficiary who has permanent urinary incontinence or permanent urinary retention. Permanent urinary retention is defined, by the coverage articles, as retention that is not expected to be medically or surgically corrected in that beneficiary within 3 months. If the catheter or the external urinary collection device meets the coverage criteria, then the related supplies that are necessary for their effective use are also covered.

For coudé tip catheters, the most common error is failure to maintain documentation of the medical necessity of the coudé tip catheter in the beneficiary's medical record. An example of such documentation would be the documented inability to catheterize with a straight tip catheter. The use of a coudé tip indwelling catheter (HCPCS A4340) for a female beneficiary is rarely reasonable and necessary, and requires documentation of the medical necessity. Urological supplies billed without a KX modifier (the KX modifier signifies that requirements specified

in the medical policy have been met) will be denied as noncovered. Suppliers must provide documentation of medical necessity upon request.

Examples of Improper Payments due to Insufficient Documentation for Coudé Tip Catheters

Insufficient Documentation – No clinical records

A medical supply company billed for HCPCS A4352 for intermittent urinary catheter (coudé) and lubricant for date of service in August 2013. The submitted documentation included a signed and dated order for urinary supplies and the proof of delivery information. The order included a check-off box to indicate that the beneficiary had a diagnosis of urinary retention not otherwise specified and a check-off box to select a quantity of 450 catheters for a 90 day supply. A one page document was also received which consisted of two sentences typed on a urologist's letter head indicating that the beneficiary required coudé catheters due to a history of benign prostatic hypertrophy. There was a typed name without credentials at the bottom of the document and there was no practitioner's signature.

The submitted documentation was missing the following: 1) the treating physician's clinical documentation to support that the beneficiary has permanent urinary incontinence or urinary retention, and 2) the physician's clinical documentation to support the need for coudé catheters. A request for additional documentation resulted in the receipt of a note that read, "no record of patient being seen since February 2012."

This claim was scored as an insufficient documentation error and the Medicare Administrative Contractor (MAC) recouped payment for HCPCS A4352 and the associated item (HCPCS A4332 - lubricant, individual sterile packet, each) from the medical supply company.

Note on "check boxes"

Check boxes are not a substitute for clinical documentation of the medical necessity of coudé catheters in the beneficiary's medical record. See the "Medicare Program Integrity Manual," [Chapter 3](#), Section 3.3.2.1.1 for more on the use of "check boxes."

Insufficient Documentation – Missing detailed written order

A medical supply company billed for a 90 day supply of HCPCS A4352 (360 units; intermittent urinary catheter; coudé (curved) tip, and HCPCS A4332 (360 units lubricant, individual sterile packets), for a date of service in October 2013. The documentation submitted, in response to an initial request for medical records, included clinic notes from 2008-2010 indicating that the patient had a history of a transurethral resection of the prostate and had a neurogenic bladder. Proof of delivery on the billed date of service was submitted. After the medical reviewer requested additional documentation, a medical record of a home visit by a family practice nurse practitioner (NP) was received; it was dated in January 2014, was labelled as a new patient consultation, and noted a history of benign prostatic hypertrophy with urinary obstruction (based on his interview with the patient). The NP's note stated that the beneficiary performed intermittent self-catheterizations seven times daily. The NP's physical examination was limited to vital signs and comments on the beneficiary's general appearance (such as "well-developed, well-nourished").

The only detailed written order that was submitted was dated May 2010 and indicated that it was a "lifetime" order for self catheterizations four times per day. However, the detailed written order was not from the referring physician whose NPI (National Provider Identifier) was on the claim, nor was it from the physician whose clinical notes from 2008-2010 were submitted, nor was it from the NP who saw the beneficiary in January 2014.

This claim was scored as an insufficient documentation error and the MAC recouped payment for the HCPCS A4352, and the associated item, HCPCS A4332, from the medical supply company.

Resources

You can find more information on how to avoid errors on claims for Urological Supplies by reviewing the following:

Local Coverage Determinations, for example, [L11581](#), and Articles, for example, [A25377](#).

Comprehensive Error Rate Testing (CERT): Nasal Endoscopy

Provider Types Affected: Physicians and Other Health Care Providers

Background

Nasal endoscopy is an examination of the inside of the nose and/or sinuses performed with direct vision using a rigid nasal endoscope and/or a flexible fiberoptic endoscope.

The CERT contractor conducted a special study of Healthcare Common Procedure Coding System (HCPCS) codes 31231 and 31233, diagnostic nasal endoscopy Part B claims submitted from April through June 2014.

The long descriptions of these HCPCS codes are:

- 31231 - Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)
- 31233 - Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)

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. When the CERT reviews a claim, all lines submitted on the claim undergo complex medical review.

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

- The correct date of service;
- The reason for performing the procedure;
- The results of the procedure;
- A physician's signature; and/or
- A signature log or attestation for an illegible signature.

Examples of Improper Payments due to Insufficient Documentation for a Nasal Endoscopy

Insufficient Documentation – Illegible Records and Missing Signature

An otolaryngologist billed for HCPCS 99214, an established patient office visit, with modifier 25, and HCPCS 31233 for a date of service in May 2014. The submitted office note was partially illegible and was not signed. An additional request for documentation did not result in a signature attestation or a legible copy of the office note; the otolaryngologist only sent a duplicate of the unsigned partially illegible documentation. This claim was scored as an insufficient documentation error and the Medicare Administrative Contractor (MAC) recouped payment for the HCPCS 99214 and the HCPCS 31233 from the otolaryngologist.

The office note is an essential part of the medical record required to support the medical necessity for the billed diagnostic nasal sinus endoscopy. The CERT reviewer will accept transcribed versions of the illegible office visit notes submitted along with the original version and an attestation from the provider.

The otolaryngologist can correct the error and retain payment for the endoscopy and the office visit by submitting a completed signature attestation and a transcribed version of the illegible office visit notes. An example of a signature attestation statement is available on the [CERT Provider Website](#).

Insufficient Documentation – Missing Complete Documentation

An otolaryngologist billed for HCPCS 99203, a level 3 office or other outpatient visit for the evaluation and management (E&M) of a new patient, with modifier 25, and HCPCS 31231 for a date of service in March 2014. The submitted documentation included an office note that stated, "Nasal Sinus Endoscopy - clear with no

evidence purulent drainage; presented with 7 week history of cough following flu and bronchitis – improving." There was no other information included in the medical record. The submitted documentation did not support the level of services provided. The CERT scores such claims as insufficient documentation errors because there is not adequate documentation to make an informed decision that the services billed were medically necessary.

This claim was scored as an insufficient documentation error and the MAC recouped payment for the HCPCS 99203 and the HCPCS 31231 from the otolaryngologist.

Resources

You can find more information on how to avoid errors on claims for diagnostic procedures at:

The "Medicare National Coverage Determinations (NCD) Manual," [Chapter 1, Part 2](#), Section 100.2, covers Endoscopy.

Additional information is available by searching for Endoscopy in the [Local Coverage Determinations Alphabetical Index](#).

Comprehensive Error Rate Testing (CERT): Lithotripsy (using extracorporeal shock wave)

Provider Types Affected: Physicians and Other Health Care Providers

Background

The CERT contractor conducted a special study of Healthcare Common Procedure Coding System (HCPCS) code 50590, lithotripsy (using extracorporeal shock wave) Part B claims submitted from April through June 2014. The long description for HCPCS code 50590 is Lithotripsy, extracorporeal shock wave.

Lithotripsy is a noninvasive procedure that uses shock waves to break up stones that sometimes form in the urinary tract (kidneys, ureters, or bladder). Usually lithotripsy is extracorporeal, which means that the high-energy shock waves are generated outside the body. Lithotripsy may also be referred to as ESWL (extracorporeal shock wave lithotripsy). After the stones are broken into tiny pieces, they are voided out of the urinary tract in urine.

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. When CERT reviews a claim, all lines submitted on the claim undergo complex medical review.

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

- The correct date of service;
- Medical records documenting the reason for performing the procedure;
- Medical records documenting the results of the procedure;
- A physician's signature; and/or
- A signature log or attestation for an illegible signature.

Examples of Improper Payments due to Insufficient Documentation for a Lithotripsy - and what to do if this happens to you

Insufficient Documentation – Missing Records and a Missing Signature

A urologist billed for HCPCS 99218 (initial hospital observation evaluation and management (E&M) service) with modifier 57, and for HCPCS 50590 for a date of service in December 2013. Modifier 57 indicates an E&M service that resulted in the initial decision to perform the surgery.

The submitted documentation included an unsigned operative note for the lithotripsy procedure for the billed date of service. There were no medical records or hospital notes for the initial hospital observation E&M service. After a request for additional documentation, the CERT reviewer received a duplicate unsigned operative report; the provider did not submit a signature attestation or documentation of the E&M service.

This claim was scored as an insufficient documentation error and the Medicare Administrative Contractor (MAC) recouped the payment for both lines on the claim (HCPCS 99218 and HCPCS 50590) from the urologist.

Corrective Action: The urologist can correct the error and retain payment for the lithotripsy by submitting a completed signature attestation, and can retain payment for the E&M by submitting the medical record documentation supporting the E&M level billed. The CERT reviewer accepts late documentation even after the due date. However, CERT will not review documentation received after the due date if an appeal has been initiated.

Insufficient Documentation – Missing Signatures

A urologist billed for HCPCS 50590 and a cystoscopy with stent insertion (HCPCS 52332) for a date of service in May 2014. The submitted documentation included a pre-procedure consultation report (including history and physical examination, assessment and plan) that was not signed by the urologist. A dictated operative note for the lithotripsy procedure was submitted but it was not signed. Any note or report that is dictated or transcribed but not signed is not valid for Medicare payment.

This claim was scored as an insufficient documentation error and the MAC recouped the payment for both lines on the claim (HCPCS 50590 and HCPCS 52332) from the urologist.

Corrective Actions: 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 signed 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.

Resources

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

[National Coverage Determination 230.1](#) – Treatment of Kidney Stones, which is on the Centers for Medicare & Medicaid Services (CMS) website.

The “Medicare Program Integrity Manual,” [Chapter 3](#), paragraph 3.3.2.4.D - Signature Requirement, and paragraph 3.3.2.5 –Amendments, Corrections and Delayed Entries in Medical Documentation, provide additional information.

Comprehensive Error Rate Testing (CERT): Lumbar Spinal Fusion

Provider Types Affected: Physicians and Suppliers

Background

Degenerative conditions of the lumbar spine are common and include spinal stenosis, degenerative spondylolisthesis, degenerative lumbar scoliosis, and degenerative disc disease. These degenerative conditions can lead to pain and disability. When these problems occur and conservative treatment (that is, non-surgical, physical therapy, injections) fails, surgery becomes an option. For some conditions, conservative treatment may not be appropriate (for example, tumor or infection, severe or increasing weakness, numbness, or bladder and bowel symptoms).

Spinal fusion is surgery to permanently join together two or more bones (vertebrae) in the spine so there is no movement between them.

CERT conducted a special study of claims with lines for arthrodesis (fusion) of the lumbar spine Healthcare Common Procedure Coding System (HCPCS) codes 22612 and 22633, submitted from January through March 2014. When CERT reviews a claim, all lines submitted on the claim undergo complex medical review. The long descriptions of these HCPCS codes are:

- 22612 - Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed); and
- 22633 - Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar.

Insufficient Documentation Caused Most of the Improper Payments

The vast majority of the improper payments were due to insufficient documentation. There were no 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:

- Documentation to support the medical necessity of the procedure;
- Documentation to support performance of the service;
- The correct date of service;
- A physician signature; and/or
- A signature log or attestation for an illegible signature on a specific date of service.

Examples of Improper Payments due to Insufficient Documentation for Lumbar Spinal Fusion **Insufficient Documentation – Missing Signatures**

An orthopedic surgeon billed for HCPCS 22633 for a lumbar fusion surgical procedure with decompression, biomechanical fixation device placement, and allograft bone placement, for a date of service in February 2014. The orthopedic surgeon did not sign the operative note or the discharge summary and did not submit a signature attestation letter for the unsigned operative note or the unsigned discharge summary.

The CERT medical reviewer requested that the surgeon provide a signature attestation for the unsigned documentation; this would allow Medicare to pay the claim. The surgeon did not send an attestation but instead sent duplicate copies of the unsigned operative note and unsigned discharge summary. The surgeon sent a copy of the preoperative consultation from January 2014 which supported the medical necessity of the surgical procedure. The consultation appropriately included x-ray reports showing grade II spondylolisthesis at L4-L5 with facet arthropathy, and facet arthropathy at L5-S1 with disc space narrowing at both levels; an MRI report which showed grade II spondylolisthesis with severe central and foraminal stenosis; and documentation of failed non-surgical intervention.

Despite support for the medical necessity of the procedure, claim payment also requires support for performance of the service. This claim was scored as an insufficient documentation error.

Insufficient Documentation – Missing Documentation to Support Medical Necessity

An orthopedic surgeon billed for HCPCS 22612 along with seven other HCPCS codes, for a lumbar fusion surgical procedure with removal of disc, lateral approach; a lumbar fusion surgical procedure, posterior or posterolateral approach; release of lower spinal cord and/or nerves; insertion of posterior spinal instrumentation for spinal stabilization, 3 to 6 vertebral segments; insertion of spinal instrumentation for spinal stabilization; and fluoroscopic guidance for spine or spinal canal injection (the professional component), for a date of service in March 2014.

The orthopedic surgeon submitted an operative report for the billed date of service; however, there were no visit notes, consultations, lumbar spinal imaging results, or other clinical documentation supporting medical necessity for the billed spinal fusion. There was no documentation of prior conservative treatments attempted or completed, nor was there documentation of a condition that would make conservative treatment inappropriate.

To support the medical necessity of the procedure, the orthopedic surgeon must submit information such as a history including the duration/character/location/radiation of pain, any limitation of activities of daily living, a physical examination, and imaging reports specific to the surgical procedure. CERT contacts providers and sends additional documentation request letters to try to obtain missing documentation. The CERT medical reviewer requested that the orthopedic surgeon submit documentation supporting medical necessity for the billed spinal fusion but instead received a duplicate operative report.

The billing provider is responsible for supplying the requested documentation regardless of the place of service. This claim was scored as an insufficient documentation error.

Guidelines Regarding Unsupported Statements

It is important to note that supplier prepared statements and physician attestations that conservative treatment measures were completed do not by themselves provide sufficient documentation of medical necessity, even if signed by the ordering physician. For example, a claim was scored an insufficient documentation error when a physician dictated the following generalized statement as part of an operative note without providing any supporting documentation, “the patient failed conservative measures and has met all of the Medicare requirements.”

Resources

You can find more information on Spinal Fusions and how to avoid errors on claims for Lumbar Spinal Fusions in:

The “Medicare Benefit Policy Manual,” [Chapter 15](#), Section 30, Physician Services;

The “Medicare Program Integrity Manual,” [Chapter 3](#), Section 3.3.2.4.D, Signature Requirement;

Local Coverage Articles on Spinal Fusion Services, available in the [Local Coverage Determinations Alphabetical Index](#); and

Office of Inspector General Report, “[Spinal Devices Supplied by Physician Owned Distributors: Overview of Prevalence and Use](#),” October 2013.

Recovery Auditor Finding: Bevacizumab Medical Necessity

Providers Types Affected: Outpatient

Problem Description

This automated edit is to identify outpatient claims for Bevacizumab where claims are incorrectly paid based on ICD-9 codes (and effective October 1, 2015, based on ICD-10 codes) that are not payable based upon the Local Coverage Determination (LCD) in effect at the time of administration. The code J9035 Bevacizumab is the focus of this audit.

Medicare Policy

The Medicare program provides limited benefits for professional drugs. The program covers drugs that are furnished "incident to" a physician's service provided that the drugs are not usually self-administered by the patients who take them. Generally, drugs and biologicals are covered only if all of the following requirements are met:

- They meet the definition of drugs or biologicals;
- They are of the type that is not usually self-administered;
- They meet all the general requirements for coverage of items as incident to a physician's services;
- They are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice;
- They are not excluded as non-covered immunizations; and
- They have not been determined by the Food and Drug Administration (FDA) to be less than effective.

If a medication is determined not to be reasonable and necessary for diagnosis or treatment of an illness or injury according to these guidelines, the MAC excludes the entire charge (that is, for both the drug and its administration). Also, MACs exclude from payment any charges for other services (such as office visits) which were primarily for the purpose of administering a noncovered injection.

[LCD L31836](#), "Local Coverage Determination (LCD): Chemotherapy and Biologicals", Issue Date: 4/30/2011 Revision Effective Date: 01/01/2013

This policy lists a number of drugs and biologicals used to treat cancer and other acute and chronic conditions that are subject to prepay edits and/or for which coverage has been expanded to include off label usage in accordance with CMS Policy for Off Label Usage. The MAC expects the use of those drugs and biologicals not listed here to be reasonable and necessary when provided in the following circumstances: FDA-approved indications. For individual consideration of claims for off-label use of chemotherapy and biological drugs not listed herein, please see the coding article attached at the end of LCD L31836 titled "Drugs and Biologicals, Coverage of, for Label and Off-Label Uses - Supplemental Instructions Article".

[LCD L25820](#), "Drugs and Biologicals, Coverage of, for Label and Off-Label Uses (L25820)", Issue Date: 12/01/2007 Revision Effective Date: 8/11/2011 Ending Date 10/16/2011

An off-label/unlabeled use of a drug is defined as a use for a non-FDA approved indication, that is, one that is not listed on the drug's official label/prescribing information. An indication is defined as a diagnosis, illness, injury, syndrome, condition, or other clinical parameter for which a drug may be given. Off-label use is further defined as giving the drug in a way that deviates significantly from the labeled prescribing information for a particular indication. This includes but is not necessarily limited to, dosage, route of administration, duration and frequency of administration, and population to whom the drug would be administered. Drugs used for indications other than those in the approved labeling may be covered under Medicare if it is determined that the use is medically accepted, taking into consideration the major drug compendia, authoritative medical literatures, and/or accepted standards of medical practice. Determinations as to whether medication is reasonable and necessary for an individual patient are made on appeal on the same basis as all other such determinations (such as with support from the peer-reviewed literature, with the advice of medical

consultants, with reference to accepted standards of medical practice, and in consideration of the medical circumstance of the individual case).

Guidance to Provider to Avoid Coding Errors

Physicians are encouraged to review the lists of codes that support medical necessity for Bevacizumab procedure codes. These may be found in your MAC's LCD, 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.

Resources

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

The "Medicare Claims Processing Manual," [Chapter 1](#), Section 80.3.2. Consistency Edits;

The "Medicare Benefit Policy Manual," [Chapter 15](#), Section 50 – Drugs and Biologicals;

The "Medicare Benefit Policy Manual," [Chapter 16](#), Section 20 - General Exclusions from Coverage;

The "Medicare Claims Processing Manual," [Chapter 17](#), Section 90.2 – Drugs, Biological, and Radiopharmaceuticals; and

[LCD L31836](#), "Local Coverage Determination (LCD): Chemotherapy and Biologicals" Issue Date: 4/30/2011. Revision Effective Date: 01/01/2013 Contract Code 15101.

Recovery Auditor Finding: Facility vs. Non-Facility

Provider Types Affected: Physician

Problem Description

The purpose of an automated edit on the place of service (POS) code is to ensure that the physician is reporting the correct POS when services are rendered in a facility entity.

Medicare Policy

Under the physician fee schedule, some procedures have a separate Medicare fee schedule for a physician's professional services when provided in a facility and a non-facility. CMS furnishes both fees in the Medicare Physician Fee Schedule Database (MPFSDB) update.

Professional fees, when the services are provided in a facility, are applicable to procedures furnished in the facilities. Site of service payment differentials also apply in an inpatient psychiatric facility and in a comprehensive inpatient rehabilitation facility.

POS is used to identify where the procedure is furnished. The list of facilities where a physician's professional services are paid at the facility rate include:

- In hospitals (POS code 21-23);
- In skilled nursing facilities (SNF) for a Part A resident (POS code 31);
- In comprehensive inpatient rehabilitation facilities (POS 61);
- In inpatient psychiatric facilities (POS 51);
- In community mental health centers (CMHC) (POS code 53);

A required piece of information, when submitting claims to Medicare, is the POS code. The POS code reflects the actual location of where the service(s) is performed. There are many procedure codes listed within the CPT where the description of the code indicates the place of service of where the item or service was rendered. Providers are encouraged to take a look at the information below to verify that they are using the correct POS codes when submitting the claims to Medicare. Incorrect use of the POS codes can negatively impact reimbursement or worse potentially lead to an investigation for fraudulent billing practices. For listing of POS codes, see the [Place of Service Code Set](#) on the CMS website.

Guidance for Providers to Avoid Errors

Providers are encouraged to review the relevant place of service code lists and encourage billing staff to use the correct codes. Incorrect place of service codes has been an ongoing problem, but one that is easy to correct by using the resources available.

Resources

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

The "Medicare Claims Processing Manual," [Chapter 12](#), Section 20.4.2;

The [Place of Service Code Set](#) on the CMS website; and

The Office of Inspector General's (OIG's) [Review of Place of Service Coding for Physician Services on Wisconsin Physician Service](#) Insurance Corporation.

Recovery Auditor Finding: Pulmonary Diagnostic Procedures and Evaluation & Management (E&M) Services

Provider Types Affected: Professional Services

Problem Description

The Recovery Auditor conducted an automated review and identified overpayments associated with limited E&M services (99211-99212) billed without modifier 25 on the same date of service as a pulmonary diagnostic procedure (94010-94799).

Medicare Policy

According to the National Correct Coding Initiative Policy Manual for Medicare Services, when a physician performs a pulmonary function study, and obtains a limited history and exam, separately coding for an E&M service is inappropriate. If a significant, separately identifiable service is performed unrelated to the technical performance of the pulmonary function test, an E&M service may be reported with modifier 25. The American Medical Association (AMA) Current Procedural Terminology (CPT) Manual Procedure Guidelines and CPT Assistant further support the inclusion of evaluation and management services.

Guidance for Providers to Avoid Errors

Professionals are urged to review the National Correct Coding Initiative Policy Manual, Chapter 11, Section J.2, which explains when it is appropriate to bill for E&M services.

Resource

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

[The "National Correct Coding Initiative Policy Manual"](#) is available on the CMS website. Once at this page, scroll to the "Downloads" section to retrieve the manual.

Recovery Auditor Finding: Injections of the Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton's Neuroma not supported by Diagnosis JE (Previously J1)

Provider Types Affected: Professional (Physician/Non-Physician)

Problem Description

Recovery Auditors performed an automated review based on a sample of claims in 2010 and 2011 involving the states of California, Hawaii, and Nevada. Per LCD L28271, for dates of service on or after September 2, 2008, through September 15, 2013, and LCD L33716 for dates of service on or after September 16, 2013, only specific diagnoses are covered for injections of the tendon, ligament, ganglion cyst, tunnel syndromes, and Morton's neuroma. Current Procedure Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Codes and ICD-9 Codes (ICD-10 Codes as of October 1, 2015) are required per LCD L28271 and L33716 based on the dates of service above.

HDI Data Analysis by the Region D Recovery Auditor of claim data identified claims with improper payments. The claims in the audit indicated injections of the tendon, ligament, ganglion cyst, tunnel syndromes, and Morton's neuroma were billed and paid without a covered diagnosis. LCD L28271 and LCD L33716 provide a list of the codes that support medical necessity for these injections. They are the only covered codes that support medical necessity.

NOTE: CPT Code 64450 was removed from LCD L28271 for dates of service on or after July 29, 2013.

Claims in the audit were reopened under Section 1869(b)(1)(G) of the Social Security Act and 42 CFR 405.980(a)(1).

Medicare Policy

Services are not covered if the appropriate diagnosis codes are not billed. The lack of a proper diagnosis code for injections of the tendon, ligament, ganglion cyst, tunnel syndromes, and Morton's neuroma resulted in overpayments in the claims audited.

Guidance on How Providers Can Avoid These Problems

Review the official coding guidelines for such injections and review Medicare's relevant LCDs and manual instructions to ensure that a proper diagnosis code is used. Also, be sure that the medical records support medical necessity of the injections.

Resources

Review LCD L28271 and LCD [L33716](#) (based on the date of service relevant to each LCD) to find the proper coding and include it in the claim. Where specific and correct coding is not included in a claim, an overpayment may result. This coding is listed in the LCDs and explained in the "[General Information](#)" section of the LCD.

Review [Chapter 5, Section 20.12](#) of the "Medicare Contractor Beneficiary and Provider Communications Manual," which refers to injections for ganglion cysts.

Recovery Auditor Finding: Incorrect Billing of Hydration Therapy - OP

Provider Types Affected: Outpatient Hospitals - Unspecified

Problem Description

A Recovery Auditor review of claims found that providers are billing Hydration Therapy with diagnosis codes that are not considered reasonable and medically necessary for applicable Local Coverage Determinations (LCDs). These codes are not included in the list of covered ICD-9 (and ICD-10 codes as of October 1, 2015) codes in the applicable LCD. Such errors are resulting overpayments for which providers are liable. The LCD

relevant to this issue is [LCD L32738](#), and affects states located in CMS Medicare Region 6 (New Mexico, Texas, Oklahoma, Arkansas, and Louisiana), as well as Mississippi (Region 4) and Colorado (Region 8).

Medicare Policy

The [LCD L32738](#), including a PDF download, is available on the CMS website.

Section 1862(a)(1)(A) of the Social Security Act states that, “no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.” Within the LCD, appropriate type of bill codes, revenue codes, and Current Procedure Terminology (CPT) and HCPCS codes are included.

NOTE: Providers are reminded that [LCD L32738](#) clearly states that, “It is the provider’s responsibility to select codes carried out [at] the highest level of specificity and selected from the ICD-9-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.” Effective October 1, 2015, the ICD-10-CM code book would apply.

Example

A frail 85-year-old man was hospitalized for pneumonia. The infection was resolved, but the patient, who had previously maintained adequate nutrition, will not eat or eats poorly. The patient is discharged to the Home Health Agency for monitoring of fluid and nutrient intake and assessment of the need for tube feeding. Observation and monitoring by skilled nurses of the patient’s oral intake, output, and hydration status is required to determine what further treatment or other intervention is needed. The patient’s necessity for skilled observation and treatment must be documented at each home health visit, until the patient’s clinical condition and/or treatment regimen has stabilized. (This example is from [Chapter 7](#), Section 40.1.2.1 of the “Medicare Benefit Policy Manual.”)

Auditor Finding

Samples of claims with dates of service from September 25, 2012, to August 30, 2013, were reviewed for this issue.

Claims reviewed by Recovery Auditors with regard to this issue included those paid that had a line reimbursement of greater than \$10, which were deemed as overpayment claims containing Healthcare Common Procedure Coding System (HCPCS) codes without diagnosis codes included in the applicable LCD.

Guidance on How Providers Can Avoid These Problems

Review [LCD L32738](#) in its entirety, effective April 9, 2015, for medical necessity and coding information related to Hydration therapy so that incorrect or unnecessary claims do not result in overpayments for which providers would be liable.

Review appropriate sections regarding Hydration Therapy in the “Medicare Claims Processing Manual,” [Chapter 12](#), Section 30.5, and the “Contractor Beneficiary and Provider Communications Manual,” [Chapter 5](#).

Recovery Auditor Finding: Incorrect Billing of DME Orthotics

Provider Types Affected: DME Non-Physicians – Orthotics

Problem Description

A review of claims involving the provision of Durable Medical Equipment (DME) orthotics has identified overpayments where ICD-9 codes were not in accordance with billing requirements outlined in Local Coverage Determinations (LCDs) for DME orthotics. Providers are reminded that when billing Healthcare Common Procedure Coding System (HCPCS) code(s) for certain DME orthoses, an ICD-9 code (effective October 1,

2105, an ICD-10-CM code) from the LCD indicating a covered diagnosis must be submitted. Claims that do not have a supported diagnosis will be considered not reasonable and necessary. Samples of claims with dates of service from December 17, 2013, to February 17, 2014, were reviewed for this issue.

Medicare Policy

The applicable LCD for this issue is [L22664](#) (“Knee Orthoses”), effective for services performed on or after May 1, 2015. From that LCD, DME providers are reminded that, “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 MAC.”

Based on Error Code 2500, the Recovery Auditors found that there was sufficient/excessive documentation in the records for reviewers to make an informed decision that the DME items were not medically necessary. There was also affirmative evidence that shows there was an improper diagnosis or deficient treatment plan, reasonably connected to the provision of unnecessary medical services or treatment for an illness/injury not applicable to improving a patient’s condition. Claims reviewed by Recovery Auditors with regard to this issue included those paid that had a line reimbursement of greater than \$10, and included the use of an HCPCS code for DME Orthoses. Also, the claims did not include an ICD-9 code to support medical necessity. Such claims were determined to be overpayments and the MACs initiated the recovery of those payments.

NOTE: For HHA claims, this criteria was applied only in cases where the HHA beneficiary was not homebound.

Guidance on How Providers Can Avoid These Problems

Providers delivering orthotics services should stay abreast of the LCDs on the CMS website regarding these services. The LCDs available on that website address claims issues based on date of service.

Resources

Review LCD [L22664](#) in its entirety, effective May 1 2015, for medical necessity and coding information related to DME Orthoses so that incorrect or unnecessary claims do not result in overpayments for which providers would be liable. The LCD includes coding and billing information in great detail specific to this issue.

Review appropriate sections regarding DMEPOS found in recently released MLN Matters® articles, including [MM9059](#), [MM9079](#), and [MM9177](#), available on the CMS website.

Review the CMS MLN Fact Sheet entitled, “[The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\)](#)” for more information.

Review [Chapter 20](#), Sections 10 through 30 and Section 130.1 of the “Medicare Claims Processing Manual.” This section is dedicated to correct billing of DMEPOS services, including Orthotics, which are covered in multiple sections.

Review [Chapter 5](#) of the “Medicare Program Integrity Manual,” entitled, “Items and Services Having Special DME Review Considerations.”



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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