

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



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Medicare Quarterly Provider Compliance Newsletter

Guidance to Address Billing Errors

A blue starburst graphic with a white border, containing text about an updated provider index.

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:



Ambulance
Suppliers



Physicians



Providers



Independent
Diagnostic Testing
Facilities



Hospitals



Ambulatory Surgery
Centers



Outpatient Providers



Durable Medical
Equipment Suppliers

Comprehensive Error Rate Testing (CERT): Advanced Life Support (ALS) Ambulance Services

Provider Types Affected: Ambulance Suppliers

Background

The CERT contractor reviewed claims for Advanced Life Support (ALS) ambulance services for the 2015 report period. The CERT contractor reviewed claims containing Healthcare Common Procedure Coding System (HCPCS) codes for ambulance services, including:

- A0425 - Ground mileage, per statute mile
- A0426 - Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1)
- A0427 - Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 - emergency)

Medicare covers ambulance services, including fixed wing and rotary wing ambulance services, only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. The beneficiary's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary.

An ALS assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service. ALS intervention means a procedure that is, in accordance with State and local laws, required to be furnished by ALS personnel.

The beneficiary's own signature is required on the claim unless the beneficiary has died or the other provisions apply. "The claim" includes the actual claim form or such other form that contains adequate notice to the beneficiary or other authorized individual that the purpose of the signature is to authorize a provider or supplier to submit a claim to Medicare for specified services furnished to the beneficiary. If the beneficiary is physically or mentally incapable of signing the claim, Medicare allows that the claim may be signed on his or her behalf by certain specified individuals (See [42 Code of Federal Regulations \(CFR\) 424.36](#)).

What You Should Know

- ◆ ALS intervention means a procedure that is, in accordance with State and local laws, required to be furnished by ALS personnel.

Helpful Links

The "Medicare Claims Processing Manual," [Chapter 15](#), especially Section 20.5 on Documentation Requirements.

Finding: Insufficient Documentation Causes Most Improper Payments

For the 2015 report period, the improper payment rate for ALS services was 14.5 percent with improper payments projected at \$226 million.

Most improper payments discovered were due to insufficient documentation. Insufficient documentation means that something was missing from the medical records. For example, there was:

- No signature authorizing the supplier of ambulance services to bill Medicare for specified services furnished to the beneficiary; or
- No support for the medical necessity of the level of service provided.

Examples of Insufficient Documentation

Insufficient Documentation – Missing documentation of medical necessity for level of service provided

An ambulance company (supplier) billed for HCPCS A0427 (ALS 1-emergency) and mileage. Clinical documentation to support medical necessity for the billed ALS emergency service on the date of service was missing. The submitted documentation included a Fire Department report describing a beneficiary complaining of weakness, nausea, vomiting, and severe back pain. The date of service was the beneficiary's fourth post-operative day (the surgical procedure was not specified). This claim was scored as an insufficient documentation error.

NOTE: The CERT defines insufficient documentation errors as those situations where one of the following occurs:

- The medical documentation submitted is inadequate to support payment for the services billed; or
- The CERT contractor reviewers could not conclude that the billed services were actually provided, were provided at the level billed, and/or were medically necessary; or
- A specific documentation element that is required as a condition of payment is missing, such as a physician signature on an order, or a form that is required to be completed in its entirety.

This is distinguished from a medical necessity error. A medical necessity error is when the CERT contractor reviewers receive adequate documentation from the medical records submitted to make an informed decision that the services billed were not medically necessary based upon Medicare coverage and payment policies.

Insufficient Documentation – Missing signature

An ambulance supplier billed for HCPCS A0427 (ALS 1-emergency) and mileage from the beneficiary's residence to a hospital. The submitted records were missing a signed copy of the Assignment of Benefits (AOB). The AOB authorizes the supplier of ambulance services to bill Medicare. The AOB is signed by the beneficiary or a responsible party. If certain conditions and documentation requirements are met, the ambulance supplier can submit documentation to support that no other qualified person was willing or available to sign the AOB on behalf of the beneficiary. The submitted documentation included an ambulance report for the date of service that was signed by an Emergency Medical Technician (an employee of the ambulance

supplier) that included support for medical necessity for the transport. However, there was no signature from the beneficiary or a responsible party and there was no medical record documentation. In response to a request for additional documentation, a letter was received that stated in part ".....After reviewing our files we do not have the Assignment of Benefits signed by the beneficiary or responsible party....." This claim was scored as an insufficient documentation error.

The ambulance supplier could have prevented this error by requesting and obtaining a signed document from the receiving hospital.

Insufficient Documentation – Missing signature

An ambulance supplier billed for HCPCS A0427 (ALS1 - emergency) and ground mileage for 1 unit of service. The submitted documentation was missing a copy of the AOB. There was no documentation showing that there was no other qualified person willing or available to sign the AOB on behalf of the beneficiary. There was no signed documentation from the receiving facility indicating the date and time of arrival. The submitted documentation included a letter that stated "Base rate A0427 should be A0429, Mileage A0425 should be 4.0 miles. Thank You." A review of Medicare's claims database showed that the supplier cancelled the claim four months after the date of claim adjudication by CERT. When suppliers or providers cancel improper claims after the date of claim adjudication, CERT must still count such claims as errors. This claim was scored as an insufficient documentation error.

Insufficient Documentation – Missing documentation of medical necessity for level of service provided and missing signature

An ambulance supplier billed for HCPCS A0427 (ALS1-emergency) and mileage. The claim was missing the following: 1) signature, date, and time of the receiving facility employee who received the beneficiary on this date of service, and 2) documentation to support medical necessity for ALS ambulance transportation for nausea. The submitted documentation included a patient care report that documented nausea and a code for a "Non-Emergent" destination. An additional request for documentation returned duplicate documentation. This claim was scored as an insufficient documentation error.

Resources

You will find more information on avoiding these errors of insufficient documentation in the following resources:

- ✓ [Medicare Ambulance Transports](#), a booklet designed to educate providers about Medicare ambulance transports;
- ✓ [Quick Reference Information: Coverage and Billing Requirements for Medicare Ambulance Transports](#);
- ✓ [Ambulance Fee Schedule](#), a publication about Medicare payment policy for ambulances;
- ✓ "Medicare Claims Processing Manual," [Chapter 15](#), especially Section 20.5 on Documentation Requirements; and
- ✓ [42 Code of Federal Regulations \(CFR\) 424.36](#).

Comprehensive Error Rate Testing (CERT): Nerve Conduction Studies

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IDTFs

Provider Types Affected: Physicians and Providers, including Independent Diagnostic Testing Facilities (IDTFs)

Background

[42 Code of Federal Regulations \(CFR\) Section 410.32](#) states that all diagnostic tests must be ordered by a physician who is treating the beneficiary, and test results must be used in the management of the beneficiary's specific medical problem. In addition, [42 CFR Section 410.33](#) states that all procedures performed in an independent diagnostic testing facility (IDTF) must be ordered by a treating physician who had a relationship with the beneficiary prior to the performance of the testing and who uses the results in the management of the beneficiary's specific medical problem.

In order to diagnose nerve damage or destruction, nerve conduction studies may be ordered. Nerve conduction studies (also called nerve conduction velocity tests) test how fast electrical signals move through a nerve.

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. For example, there was:

- No order for the diagnostic test and/or no documentation of the intent to order the diagnostic test;
- No documentation of the medical necessity of the diagnostic test; and/or
- No physician's signature on the report of the results.

What You Should Know

- ◆ By regulation, Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants may perform diagnostic tests (pursuant to state law), and are treated as a physician for the ordering of tests, but are not a "physician" for the purpose of technician supervision.

Helpful Links

The "Medicare Benefits Policy Manual," Pub.100-02, [Chapter 15](#), Section 80, which explains that diagnostic tests falling under the Social Security Act, Section 1861(s)(3), are not under the "incident to" services created by section 1861(s)(2).

Example of Improper Payments due to Insufficient Documentation

Insufficient Documentation for Nerve Conduction Studies – Missing Orders and Missing Clinical Documentation

A physical medicine and rehabilitation physician billed for nerve conduction studies. The submitted documentation was missing a physician order or clinical documentation of intent to order the billed nerve conduction studies. The documentation was also missing signed and dated clinical documentation to support the medical necessity for the billed nerve conduction studies. Although the claim included a valid ICD-10 code, the ICD-10 code alone is not considered sufficient information to support the medical necessity of the studies. The submitted documentation consisted only of a signed report. There was no response to additional requests for documentation from either the billing provider or the ordering/referring provider. This claim was scored as an insufficient documentation error.

Resources

You will find more information on avoiding errors of insufficient documentation in the following resources:

- ✓ “Medicare Benefits Policy Manual,” Pub. 100-02, [Chapter 15](#), Section 80 explains that diagnostic tests falling under the Social Security Act, Section 1861(s)(3), are not under the “incident to” services created by Section 1861(s)(2). Supervision requirements for diagnostic tests originally appeared in Change Release (CR) 850 and are periodically updated in the Physician Fee Schedule Database. By regulation, Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants may perform diagnostic tests (pursuant to state law), and are treated as a physician for the ordering of tests, but are not a “physician” for the purpose of technician supervision.
- ✓ Local Coverage Determinations (LCDs) for Nerve Conduction Studies, including [L34859](#), [L35048](#), [L35081](#), [L35098](#), and [L34325](#);
- ✓ [42 Code of Federal Regulations \(CFR\) Section 410.32](#); and
- ✓ [42 CFR Section 410.33](#).



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Comprehensive Error Rate Testing (CERT): Observation Services

Provider Types Affected: Hospitals and Physicians

Background

Evaluation and Management (E/M) services are divided into broad categories, then subcategories and finally levels of service. Considerations in selecting the correct E/M include the type of service, place of service and the patient's status. Providers use Healthcare Common Procedure Coding System (HCPCS) codes for observation services when they provide E/M services to beneficiaries admitted to observation; there does not have to be a designated observation area in the hospital in order to bill these codes.

The HCPCS codes for observation services include:

- 99217 - observation care discharge
- 99218 - initial observation care
- 99219 - initial observation care
- 99220 - initial observation care
- 99224 - subsequent observation care
- 99225 - subsequent observation care
- 99226 - subsequent observation care

Problem Description

During the 2014 report period, the improper payment rate for evaluation and management (E/M) services was 14.6 percent, accounting for 9.3 percent of the overall Medicare Fee-For-Service (FFS) improper payment rate. The projected improper payment amount during the 2014 report period was \$4.5 billion. E/M services remain a leading cause of improper payments.

What You Should Know

- ◆ The projected improper payment amount for E/M services during the 2014 report period was \$4.5 billion.

Helpful Links

"Medicare Claims Processing Manual," [Chapter 12](#), Section 30.6, Evaluation and Management Service Codes.

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. For example, there was:

- No order for observation services;
- No progress notes; or
- No physician's signature on a progress note.

Examples of Improper Payments due to Insufficient Documentation or Incorrect Coding for Observation Services

Insufficient Documentation – Missing orders and missing progress note

An internal medicine specialist billed for HCPCS 99217 (observation care discharge) for a date of service in April 2013. The submitted documentation was missing signed and dated physician's orders for observation services and was also missing a signed and dated progress note to support a face-to-face encounter on the date of service. Submitted documentation included a discharge summary for the date of service, but there was no documentation of a visit with the patient. The medical reviewer requested a progress note for the date of service and received no additional clinical documentation. Additional requests for medical records returned a history and physical from the day before the date of service which was signed by a different physician. This claim was scored as an insufficient documentation error and the MAC recovered the payment.

Insufficient Documentation – Missing records for the correct date of service

An internal medicine specialist billed for HCPCS 99226 (subsequent observation care, per day) for an E/M service on November 12th. A review of Medicare's billing database showed that the facility billed for an observation stay, on a type of bill 131, for this beneficiary from November 11th through November 13th. The physician's submitted records were missing documentation of an E/M subsequent observation service on November 12th. The submitted records were also missing the facility's medical observation records for the patient; there were no dated and timed physician's orders for the observation services, nursing notes, and physician's progress notes. The submitted medical record included a document titled "History and Physical" (H&P), dated September 11th signed by the billing physician. After an additional request for documentation, the physician submitted a duplicate of the November 11th physician note signed on November



12th at 2:59 am, ambulance records, tracings, CT results, H&P for November 11th, nurse's documentation and other facility records. This claim was scored as an insufficient documentation error.

On the rare occasion when a patient remains in observation care for 3 days, the physician shall report an initial observation care code (99218-99220) for the first day of observation care, a subsequent observation care code (99224-99226) for the second day of observation care, and an observation care discharge code (99217) for the observation care on the discharge date. (See the "Medicare Claims Processing Manual," [Chapter 12](#), Section 30.6.8).

Incorrect Coding – Does not meet requirements for key components

A cardiologist billed for initial observation care, HCPCS 99220, for a date of service in May 2013. HCPCS 99220 requires 3 of 3 key components (comprehensive history, comprehensive examination, and high complexity medical decision making). The submitted documentation supported HCPCS 99218 because the physician recorded a detailed history (limited review of systems), detailed exam (5 body systems), and moderate complexity medical decision making per 1995 E/M guidelines. This claim was scored as an incorrect coding error.

When billing Medicare, a provider may choose either version of the documentation guidelines, not a combination of the two, to document a patient encounter. However, beginning for services performed on or after September 10, 2013, physicians may use the 1997 documentation guidelines for an extended history of present illness along with other elements from the 1995 guidelines to document an evaluation and management service.

Resources

You will find more information on avoiding errors of insufficient documentation in the following resources:

- ✓ [Evaluation and Management Services Guide](#), a reference tool for E/M services;

This guide contains detailed information about:

- [1995 Documentation Guidelines for Evaluation and Management Services](#),
- [1997 Documentation Guidelines for Evaluation and Management Services](#),
- ✓ [FAQ on 1995 & 1997 Documentation Guidelines for Evaluation & Management Services](#); and
- ✓ "Medicare Claims Processing Manual," [Chapter 12](#), Section 30.6, Evaluation and Management Service Codes.

Comprehensive Error Rate Testing (CERT): Screening Colonoscopy

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Provider Types Affected: Physicians, hospitals, and ambulatory surgery centers

Background

Medicare covers several types of colorectal cancer screening tests to help find precancerous growths or find cancer early, when treatment is most effective. One type of colorectal cancer screening is colonoscopy.

Healthcare Common Procedure Coding System (HCPCS) codes for screening colonoscopies include the following:

- G0105 - Colorectal cancer screening; colonoscopy on individual at high risk
- G0121 - Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk

According to Medicare coverage policy:

- High risk beneficiaries: Medicare covers screening colonoscopy once every 24 months for beneficiaries at high risk for developing colorectal cancer (at least 23 months have passed following the month in which the last covered G0105 screening colonoscopy was performed).
- Not high risk beneficiaries: For beneficiaries who are not at high risk for colorectal cancer, Medicare covers this test once every 10 years (at least 119 months have passed following the month in which the last covered G0121 screening colonoscopy was performed), or at least 47 months have passed following the month in which the last covered G0104 flexible sigmoidoscopy was performed.
- To determine the 23, 47, and 119-month periods, the count starts beginning with the month after the month in which a previous test/procedure was performed.

If during the course of the screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal along with modifier -PT should be billed and paid rather than code G0105 or G0121.

An incomplete screening colonoscopy for example, the inability to advance the colonoscope to the cecum or colon-small intestine anastomosis due to unforeseen circumstances, is billed and paid using

What You Should Know

- ◆ The CERT contractor determined that a number of claims for screening colonoscopies were in error, primarily due to insufficient documentation.

Helpful Links

Providers can access an example of an attestation statement on the [CERT Provider website](#).

screening colonoscopy codes G0105 and G0121 with modifier “-53.” The Medicare physician fee schedule database has specific values for codes G0105-53 and G0121-53. An incomplete colonoscopy performed prior to January 1, 2016, is paid at the same rate as a sigmoidoscopy. Beginning January 1, 2016, Medicare will pay for the interrupted colonoscopy at a rate that is calculated using one-half the value of the inputs for the codes.

Problem Description

The CERT contractor determined that a number of claims for screening colonoscopies were in error, primarily due to insufficient documentation. Incorrect coding is another cause of improper payments for colonoscopies. [42 Code of Federal Regulations \(CFR\) Section 410.32](#) indicates that diagnostic tests may only be ordered by the treating physician (or other treating practitioner acting within the scope of his or her license and Medicare requirements) who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician (or other qualified non-physician provider) who is treating the beneficiary are not reasonable and necessary.

Finding: Insufficient Documentation and Incorrect Coding Causes Most Improper Payments

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

- No order for the diagnostic procedure and/or no documentation of the intent to order the procedure;
- No procedure note or progress notes;
- No documentation of characteristics of the high risk individual; or
- No physician's signature on a procedure note or progress note.

Examples of Improper Payments due to Insufficient Documentation or Incorrect Coding for Colonoscopy Services

Insufficient Documentation – Missing signature attestation and missing pathology report

A gastroenterologist billed for a colonoscopy with biopsy. The submitted documentation was missing a signature attestation and a pathology report. The submitted documentation included an unsigned progress note (that would have supported the medical necessity of the procedure if it had been signed) and an unsigned procedure note. The medical reviewer made additional requests in an attempt to obtain a signature attestation, however no additional documentation was submitted. This claim was scored as an insufficient documentation error.

Note that the provider could have completed a signature attestation to correct the missing signature error. Providers can access an example of an attestation statement on the [CERT Provider website](#).

Insufficient Documentation – Missing clinical documentation

A gastroenterologist billed for a colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple. The submitted documentation was missing the treating physician's order or documentation to support the treating physician's plan or intent to order the billed colonoscopy. The submitted records were also missing a pathology report and the physician's clinical documentation supporting the medical necessity for the billed colonoscopy. The submitted medical record included a colonoscopy report signed by the billing provider. The medical reviewer requested records from the referring physician to support the intent to order the colonoscopy and received a note stating, "Not a patient here." This claim was scored as an insufficient documentation error.

Incorrect Coding - Recode to G0121

A gastroenterologist billed for a colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)). The submitted documentation included a physician's office visit note dated 6 days prior to the procedure that documented the plan/intent for a screening colonoscopy and a report of a screening colonoscopy for colorectal cancer screening for the billed date of service. The submitted physician's office visit documented the following history of present illness: "denies complaint of weight loss, rectal bleeding, or altered bowel habit" and "no reported family history of colorectal cancer in 1st degree relative." This documentation does not support the need for a diagnostic colonoscopy or that the beneficiary is high risk for colorectal cancer. The submitted procedure note documented findings of "scattered diverticular disease throughout the bowel" and a "non-bleeding internal hemorrhoid." No biopsies were taken or polyps removed so there was no evidence that the screening colonoscopy became a diagnostic procedure. The documentation supported a code change from a diagnostic colonoscopy to G0121 (Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk). This claim was scored as an incorrect coding error.



Incorrect Coding – Recode to G0121

An internist billed HCPCS 45378 (Diagnostic colonoscopy). The submitted documentation included a signed and dated procedure report for the billed date of service. Documentation from the ordering/referring provider included the following statement, "The patient is here for screening colonoscopy. It has been 14 years since her last scope." The medical reviewer requested additional documentation from the billing provider and received a duplicate report without a pathology report. The submitted documentation supported a recode from 45378 to G0121. The Medicare claims database was reviewed for frequency of billing. This claim was scored as an incorrect coding error.

Resources

You will find more information on avoiding errors on claims for screening colonoscopies in the following resources:

- ✓ [Preventive Services Chart](#), an educational tool that provides the following information on Medicare preventive services: HCPCS/ Current Procedural Terminology (CPT) codes; coverage requirements; frequency requirements; and beneficiary liability for each Medicare preventive service;
- ✓ "Medicare Benefit Policy Manual," [Chapter 15](#), Section 280.2, Colorectal Cancer Screening;
- ✓ "Medicare Claims Processing Manual," [Chapter 12](#), Section 30.1 B, Incomplete colonoscopies; and [Chapter 18](#), Section 60.2, Colorectal Cancer Screening HCPCS Codes, Frequency Requirements, and Age Requirements (If Applicable);
- ✓ [National Coverage Determination \(NCD\) 210.3](#) Colorectal Cancer Screening Tests; and
- ✓ [42 Code of Federal Regulations \(CFR\) Section 410.32](#).



OP

Recovery Auditor Finding: Bevacizumab (Avastin®) Injection, 10 mg, for indications that are not medically necessary

Provider Types Affected: Outpatient Providers

Problem Description

Potential incorrect billing occurred for claims billed for Bevacizumab with diagnosis codes that are not listed by the Medicare Administrative Contractor (MAC) as medically necessary.

This issue involves Healthcare Common Procedure Coding System (HCPCS) J9035 Bevacizumab (Avastin®) Injection 10 mg and the following related drug administration codes:

- 96413 Chemo IV Infusion up to 1 hour;
- 96415 Chemo IV Infusion, each additional hour; and
- 96317 Chemo IV Infusion, each additional sequential infusion up to 1 hour, infusion technique only, per visit.

Findings

The Recovery Auditor conducted automated reviews of claims for Bevacizumab, J9035 to determine medical necessity. When no other drug codes are on the claim, the related drug administration services are also not medically necessary and should be denied. In addition, drug wastage for Bevacizumab related to administration for non-covered indications should also be denied.

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;

What You Should Know

- ◆ Providers should ensure that Bevacizumab (Avastin®) Injection, 10 mg, should be billed only for indications that are medically necessary.

Helpful Links

The "Medicare Benefit Policy Manual," [Chapter 15](#), Section 50, Drugs & Biologicals.

- 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.

Guidance on how providers can avoid these billing errors

Providers should ensure that Bevacizumab (Avastin®) Injection, 10 mg, should be billed only for indications that are medically necessary.

Resources

You will find more information on avoiding errors on these claims in the following resources:

- ✓ "Medicare Benefit Policy Manual," [Chapter 15](#), Section 50, Drugs & Biologicals; and
- ✓ "Medicare Claims Processing Manual," [Chapter 17](#), Section 40, Drugs & Biologicals.



DME

Recovery Auditor Finding: Hospital Beds with Mattresses Billed with Group I or Group II Support Mattresses

Provider Types Affected: Durable Medical Equipment (DME) Suppliers

Problem Description

Billing for hospital beds with mattresses and Group I or II support mattresses constitutes billing for the same or similar equipment. The codes which Medicare may deny as same or similar equipment include claims for:

- E0184 - dry pressure mattress
- E0186 - air pressure mattress
- E0187 - water pressure mattress
- E0196 - gel pressure mattress
- E0277 - powered pressure-reducing air mattress
- E0373 - non-powered advanced pressure reducing mattress
- E0250 - hospital bed, fixed height, with any type side rails, with mattress
- E0255 - hospital bed, variable height, hi-lo, with any type side rails, with mattress
- E0260 - hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress
- E0265 - hospital bed, total electric (head, foot, and height adjustments), with any type side rails, with mattress
- E0290 - hospital bed, fixed height, without side rails, with mattress
- E0292 - hospital bed, variable height, hi-lo, without side rails, with mattress
- E0294 - hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress
- E0296 - hospital bed, total electric (head, foot, and height adjustment), without side rails, with mattress
- E0303 - hospital bed, heavy duty, extra wide, with weight capacity > than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress
- E0304 - hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress.

Findings

Recovery auditors conducted automated reviews for billing of the same or similar equipment. Some facts will be case-specific based on the evidence provided in the medical record.

What You Should Know

- ◆ DME Suppliers should review Local Coverage Determinations (LCDs) provided by its DME Medicare Administrative Contractor (MAC) when providing hospital beds and special mattresses to ensure that the same or similar equipment is not being supplied to a beneficiary.

Helpful Links

The “Medicare National Coverage Determination Manual,” [Chapter 1](#), Part 4, Sections 280.7 and 280.8.

Guidance on how providers can avoid these billing errors

DME Suppliers should review Local Coverage Determinations (LCDs) provided by the DME Medicare Administrative Contractor (MAC) when providing hospital beds and special mattresses to ensure that the same or similar equipment is not being supplied to a beneficiary.

Resources

You will find more information on avoiding errors on these claims in the following resource:

- ✓ The “Medicare National Coverage Determination Manual,” [Chapter 1](#), Part 4, Sections 280.7 and 280.8.



Recovery Auditor Finding: Wheelchairs and Power Mobility Devices (PMDs) Paid for Ambulatory Beneficiaries

Provider Types Affected: Durable Medical Equipment Suppliers

Problem Description

Wheelchairs are not covered for beneficiaries who are sufficiently ambulatory using a cane or walker.

Medicare Policy

As mentioned in a prior compliance newsletter article, power mobility devices, which includes power operated vehicles (POVs) and power wheelchairs (PWCs), are covered under the Durable Medical Equipment benefit (Social Security Act, Section 1861(s)(6)). In order for a beneficiary's equipment to be eligible for reimbursement, the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, added Section 1834(a)(1)(E)(iv) which provides that payment may not be made for a motorized or power wheelchair unless the practitioner who has conducted the face-to-face examination writes the 7-element order:

1. Beneficiary's name;
2. Description of item that is ordered (this description may be general (for example, "power operated vehicle," "power wheelchair," or "power mobility device") or more specific;)
3. Date of completion of the face-to-face examination;
4. Pertinent diagnoses/conditions that relate to the need for a PMD;
5. Length of need;
6. Physician's signature; and
7. Date of physician's signature.

It is a statutory requirement that all items of the 7-element order be entered specifically by, and only by, the practitioner who has conducted the face-to-face requirements. **A power mobility device may not be ordered by a podiatrist. If it is, it will be denied as noncovered.**

For a POV or PWC to be covered the treating physician must conduct a face-to-face examination of the beneficiary and the supplier must receive the 7-element order from the treating physician, containing all the

What You Should Know

- ◆ In order for a beneficiary's equipment to be eligible for reimbursement, the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met.

Helpful Links

The "Medicare National Coverage Determination (NCD) Manual," [Chapter 1](#), Part 4, Sections 280.7 and 280.8 addresses "mobility assistive equipment" (MAE) and includes within that category canes, crutches, walkers, manual wheelchairs, power wheelchairs, and scooters.

elements specified in the Documentation Requirements section of the Local Coverage Determination, within 45 days after completion of the physician’s face-to-face examination and prior to delivery of the device. (Exception: If the examination is performed during a hospital or nursing home stay, the supplier must receive the order within 45 days after discharge.) If these requirements are not met, the claim will be denied as noncovered.

If the detailed product description for the specific device is not obtained prior to delivery, payment will not be made for the item even if the documentation is subsequently obtained. If a similar item is provided by an unrelated supplier who has obtained the required documentation prior to delivery, it will be eligible for coverage.

A very detailed discussion of the face-to-face examination, including the role of licensed/certified medical professionals, such as physical or occupational therapists, is in the [April 2014 edition of the “Medicare Quarterly Provider Compliance Newsletter.”](#)

Findings

The Recovery Auditors determined that there were improper billings for canes, crutches or walker and a wheelchair, PMD, or POV (defined as a three- or four-wheeled device with tiller steering and limited seating or a scooter) for the same beneficiary. A beneficiary cannot qualify for a cane, walker or crutches and a wheelchair or POV at the same time.

Guidance on how providers can avoid these billing errors

The “Medicare National Coverage Determination (NCD) Manual,” [Chapter 1](#), Part 4, Sections 280.7 and 280.8 addresses “mobility assistive equipment” (MAE) and includes within that category canes, crutches, walkers, manual wheelchairs, power wheelchairs, and scooters. Section 280.3 of the manual addresses determining the appropriate equipment for the beneficiary. For example, can the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker? The cane or walker should be appropriately fitted to the beneficiary for this evaluation. Assess the beneficiary’s ability to safely use a cane or walker.

Resources

You will find more information on avoiding errors on these claims in the following resources:

- ✓ [April 2014 edition of the “Medicare Quarterly Provider Compliance Newsletter,”](#) and
- ✓ “Medicare National Coverage Determination (NCD) Manual,” [Chapter 1](#), Part 4, Sections 280.7 and 280.8.



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