Medicare Quarterly Provider Compliance Newsletter

Guidance to Address Billing Errors

Volume 1, Issue 2 – February 2011

Official CMS Information for Medicare Fee-For-Service Providers

Table of Contents

Introduction

The Medicare Fee-For-Service (FFS) program consists of a number of payment systems, with a network of contractors that process more than 1 billion claims each year, submitted by more than 1 million providers, such as hospitals, physicians, skilled nursing facilities, labs, ambulance companies, and durable medical equipment, prosthetics, orthotics, and supplies suppliers. These contractors, called "Medicare claims processing contractors," process claims, make payments to health care providers in accordance with Medicare regulations, and educate providers regarding how to submit accurately coded claims that meet Medicare guidelines. Despite actions to prevent improper payments, such as prepayment system edits and limited medical record reviews by the claims processing contractors, it is impossible to prevent all improper payments due to the large volume of claims. In the Tax Relief and Health Care Act of 2006, the U.S. Congress authorized the expansion of the Recovery Audit Program nationwide by January 2010 to further assist the Centers for Medicare & Medicaid Services (CMS) in identifying improper payments. Medicare FFS Recovery Auditors are contractors that assist CMS by performing claim audits on a postpayment basis.

CMS issues the Medicare Quarterly Provider Compliance Newsletter, a Medicare Learning Network® (MLN) educational product, to help providers understand the major findings identified by Medicare Claims Processing Contractors, Recovery Auditors, Program Safeguard Contractors, Zone Program Integrity Contractors, and other governmental organizations, such as the Office of Inspector General. The first issue of the newsletter is available at http://www.cms.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN904943.pdf on the CMS website. This is the second issue of the newsletter and is designed to help FFS providers, suppliers, and their billing staffs understand their claims submission problems and how to avoid certain billing errors and other improper activities, such as failure to submit timely medical record documentation, when dealing with the Medicare FFS program.

The newsletter describes the problem, the issues that may occur as a result, the steps CMS has taken to make providers aware of the problem, and guidance on what providers need to do to avoid the issue. In addition, the newsletter refers providers to other documents for more detailed information wherever they may exist.

The findings addressed in this newsletter are listed in the Table of Contents and can be navigated to directly by "left-clicking" on the particular issue. An archive of previously issued newsletters is also available to providers in case they missed one. This archive can be found at http://www.cms.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf on the CMS website.

Errata **-** October 2010 (Volume 1, Issue 1)

An incorrect reference was included in the October 2010 (Volume 1, Issue 1) Quarterly Provider Compliance Newsletter: Guidance to Avoid Billing Errors and Improper Payments entitled: "Inpatient Hospital Services: Respiratory System Diagnosis with Vent Support - Principal diagnosis on the claim did not match the principal diagnosis in the medical record" was incorrect.

The correct reference for that item should have been to the "Medicare Program Integrity Manual," Chapter 6 Section 6.5.3 A-C, available at http://www.cms.gov/manuals/downloads/pim83c06.pdf on the CMS website.

Recovery Audit Finding: Tracheostomy – Incorrect Coding

Provider Types Affected: Inpatient Hospital

Problem Description:

When a patient undergoes a revision to an existing tracheostomy, the provider should not bill for the creation of a new tracheostomy. Recovery Auditors have found that providers are inappropriately billing for the creation of a new tracheostomy when services performed only involve revising an existing tracheostomy. Hospitals should assign code 31.74 (Revision of Tracheostomy) when only a revision is performed. Recovery Auditors have performed validation for MS DRG:

- 004 – Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth & Neck Without Major Operating Room;
- 011 – Tracheostomy for Face, Mouth & Neck Diagnoses with Major Complications and Co-morbidities (MCC);
- 012 – Tracheostomy for Face, Mouth & Neck Diagnoses with Co-morbidities (CC); and
- 013 – Tracheostomy for Face, Mouth & Neck Diagnoses Without CC or MCC.

Guidance on How Providers Can Avoid These Problems:

✓When a patient is admitted to the hospital, the health condition that after physician assessment is determined to be chiefly responsible as the cause for the admission should be sequenced as the principal diagnosis (coded as an MS DRG). The other diagnoses that are identified should represent all MCCs and CCs present during the admission that impact the DRG assignment, and the Present on Admission indicator for all diagnoses reported must be coded correctly.

✓Ensure that all medical documentation entries are consistent with other parts of the medical record (assessments, treatment plans, and physician orders, nursing notes, medication and treatment records, etc. and other facility documents such as admission and discharge data and pharmacy records). If an entry is made that contradicts documentation found elsewhere in the record, clarification should be obtained and documented by the attending physician.

✓Make sure that the principal diagnosis is coded to the highest level of specificity.

✓Make certain your billing staff reviews the payment guidelines, provided in this newsletter, for correctly coding principal and secondary diagnoses and procedures.

✓The hospital's claim must match both the attending physician's description/diagnosis and the information contained in the beneficiary's medical record.

✓Review these helpful references:

- The "Medicare Program Integrity Manual," Chapter 6, Section 6.5.3 A-C and 6.5.4, are available at http://www.cms.gov/manuals/downloads/pim83c06.pdf on the CMS website.
- The "Medicare Claims Processing Manual," Chapter 3 (Inpatient Hospital Billing), Section 20 (Payment Under Prospective Payment System (PPS) Diagnosis Related Groups (DRGs)) is available at http://www.cms.gov/manuals/downloads/clm104c03.pdf on the CMS website. The "Medicare Benefit Policy Manual," Chapter 1, Section 10 at http://www.cms.gov/manuals/Downloads/bp102c01.pdf on the CMS website.
- The "ICD-9-CM Official Guidelines for Coding and Reporting," which is available at http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm on the Centers for Disease Control and Prevention website, and American Medical Association Current Procedural Terminology references to ensure complete and accurate coding.

✓Monitor Recovery Audit Program web portals to track the status of claims under Recovery Audit Program review for your facility. CMS published MLN Matters® articles with specific recommendations for providers about Recovery Audit Program websites.

Recovery Audit Finding: Not a New Patient – Incorrect Coding

Provider Types Affected: Physician

Problem Description:

Recovery Auditors determined that providers are incorrectly billing new patient services for reimbursement under Medicare Part B. New patient Evaluation and Management (E/M) services for the same beneficiary within a 3-year period should not be billed to Medicare. A problem exists when multiple new patient E/M services are reimbursed under Medicare Part B inside of this time frame.

Guidance on How Providers Can Avoid These Problems:

- ✓ Medicare interprets the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years. New patient Current Procedural Terminology codes are only payable for beneficiaries without office based face-to-face services in the previous 3 years.
- ✓ For example, if a professional component of a previous procedure is billed in a 3-year period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a "new patient" for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG, etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a "new patient."
- ✓ A "new patient" is defined in the "Medicare Claims Processing Manual," Chapter 12, Section 30.6.7, which is available at http://www.cms.gov/manuals/downloads/clm104c12.pdf on the CMS website.
- ✓ CMS published MLN Matters® Article MM4032, which defines "new patient" and references the "Medicare Claims Processing Manual," Chapter 12, Section 30.6.7. The article is available at http://www.cms.gov/MLNMattersArticles/downloads/MM4032.pdf on the CMS website.

Recovery Audit Finding: Chemotherapy Administration and Non-chemotherapy Injections and Infusions – Incorrect Coding

Provider Types Affected: Outpatient Providers and Physicians

Problem Description:

Initial infusion codes are to be reported only once per day, according to the "Medicare Claims Processing Manual," Chapter 12, Section 30.5, unless protocol requires that two separate intravenous sites are necessary. An error occurs when providers bill more than one initial infusion code per day and do not append a modifier signifying the need for different access sites on the same date of service. Recovery Auditors found that providers were incorrectly coding Chemotherapy Administration and Non-chemotherapy Injections and Infusions more than once per day without an appropriate modifier.

Guidance on How Providers Can Avoid These Problems:

Chemotherapy Administration and Non-chemotherapy Injections and Infusions are discussed in the "Medicare Claims Processing Manual," Chapter 12, Section 30.5 E, which is available at http://www.cms.gov/manuals/downloads/clm104c12.pdf on the CMS website. Providers should pay close attention to the instructions for what constitutes an "initial" service code and when to use modifier 59.

The problem cited involved claims containing the following Healthcare Common Procedure Coding System (HCPCS) Codes:

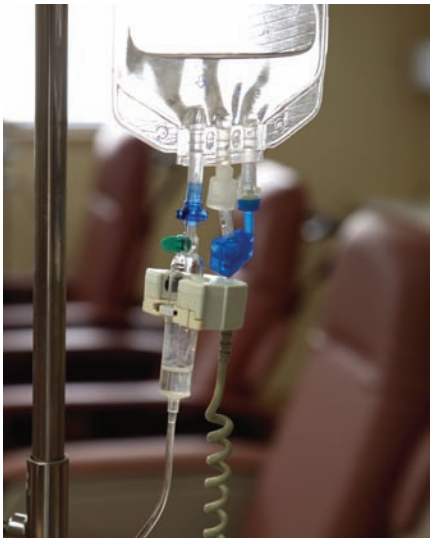
- 96413 – Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug;
- 90765 – Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour (Effective Date Range: Through 12/31/2008);
- 96365 – Intravenous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

Modifier 59 as listed in the American Medical Association (AMA) Coding and Modifier book, third edition:

"Chemotherapy administration codes include codes for the administration of chemotherapeutic agents by multiple routes, the most common being the intravenous route. Separate payment is allowed for chemotherapy administration by push and by infusion techniques on the same day, but only one push administration is allowed on a single day. It is recognized that combination chemotherapy is frequently provided by different routes at the same session. Modifier 59 can be appropriately used when two different modes of chemotherapy administration are used. Modifier 59 is used in this situation to indicate that two separate procedures were used to administer chemotherapeutic drugs, not to indicate that two separate drugs were administered."

"When the sole purpose of fluid administration is to maintain patency of the access device, the infusion is neither diagnostic nor therapeutic; therefore, the injection, infusion, or chemotherapy administration codes are not to be separately reported. If fluid administration is medically necessary for therapeutic reasons (e.g., correct dehydration or prevent nephrotoxicity) in the course of a transfusion or chemotherapy, it could be separately reported with modifier 59 because the fluid administered is medically necessary for a different diagnosis."

Be sure staff is aware of the manual chapter and article cited previously, regarding Medicare policy on billing for Infusion Chemotherapy. Ensure physician's drug orders and the dosage administration information is adequately documented.



Recovery Audit Finding: Excisional Debridement – Incorrect Coding

Provider Types Affected: Inpatient Hospital

Problem Description:

The Recovery Auditors found that providers were incorrectly coding non-excisional debridement as excisional debridement. Excisional debridement of wound, infection, or burn (86.22) is defined as the "surgical removal or cutting away of devitalized tissue, necrosis, or slough. Hospitals are incorrectly reporting excisional debridement when the wound is debrided using autolytic, enzymatic, or mechanical (whirlpool) debridement. Hospitals should assign 86.28, which is the non-excisional debridement of wound, infection, or burn for these non-excisional debridements. Recovery Auditors have performed validation for Medicare Severity Diagnosis-Related Groups (MS DRGs):

- 463 – Wound Debridement and Skin Graft Except Hand, for Musculo-Connective Tissue Disorders with Major complications and Co-morbidities (MCCs);
- 464 – Wound Debridement and Skin Graft Except Hand, for Musculo-Connective Tissue Disorders with Co-morbidities (CC);
- 465 – Wound Debridement and Skin Graft Except Hand, for Musculo-Connective Tissue Disorders without CC/MCC;
- 573 – Skin Graft and/or Debridement for Skin Ulcer or Cellulitis with MCC;
- 574 – Skin Graft and/or Debridement for Skin Ulcer or Cellulitis with CC;
- 575 – Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without CC/MCC;
- 901 – Wound Debridements for Injuries with MCC;
- 902 – Wound Debridements for Injuries with CC; and
- 903 – Wound Debridements for Injuries without CC/MCC.

Guidance on How Providers Can Avoid These Problems:

✓When a patient is admitted to the hospital, the health condition the physician determines is chiefly responsible as the cause for the admission should be sequenced as the principal diagnosis (coded as an MS DRG). The other diagnoses that are identified should represent all MCCs and CCs present during the admission that impact the DRG assignment, and the Present on Admission (POA) indicator for all diagnoses reported must be coded correctly.

✓Be sure that the medical record accurately supports the procedure and diagnosis coding.

✓Make sure that the principal diagnosis is coded to the highest level of specificity.

✓Make certain your billing staff reviews the payment guidelines provided in this newsletter for correctly coding principal and secondary diagnoses and procedures.

✓Review helpful references:

– The "Medicare Program Integrity Manual," Chapter 6, Section 6.5.3 A-C and Section 6.5.4, is available at http://www.cms.gov/manuals/downloads/pim83c06.pdf on the CMS website.

– The "Medicare Claims Processing Manual," Chapter 3, Section 20 is available at http://www.cms.gov/manuals/downloads/clm104c03.pdf, and the "Medicare Benefit Policy Manual," Chapter 1 Section 10 is available at http://www.cms.gov/manuals/Downloads/bp102c01.pdf on the CMS website.

– The "ICD-9-CM Official Guidelines for Coding and Reporting," which is available at http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm on the Centers for Disease Control website, and American Medical Association CPT references to ensure complete and accurate coding.

✓Monitor Recovery Audit Program web portals to track the status of claims under Recovery Audit Program review for your facility. CMS published MLN Matters® articles with specific recommendations for providers about Recovery Audit Program websites. These articles are available at http://www.cms.gov/MLNMattersArticles/downloads/SE1024.pdf and http://www.cms.gov/MLNMattersArticles/downloads/SE1028.pdf on the CMS website.

Recovery Audit Finding: Evaluation and Management (E/M) Billing During the Global Surgery Period

Provider Types Affected: Physician

Problem Description:

Reviews by Recovery Auditors determined that providers are incorrectly billing E/M services provided by the surgeon the day before, the day of, and up to 90 days after major surgery, and 0–10 days after minor surgery. The Global Surgical Package (GSP) was established by the CMS to ensure that all components of surgery (including pre- and postoperative services) were bundled into one payment.

Guidance on How Providers Can Avoid These Problems:

✓Under Medicare Physician Fee Schedule rules, most surgical procedures include pre- and postoperative E/M services. Physicians can indicate that E/M services rendered during the global period are not paid in the GSP by submitting modifiers 24 (Unrelated E/M Service by Same Physician During Postoperative Period), 25 (Significant, Separately Identifiable E/M Service by the Same Physician on the same day of the Procedure or Other Service), and 57 (Decision for Surgery Made Within Global Surgical Period) on the E/M service.

✓The following explanation of modifier 79 (Unrelated Procedure or Service by the Same Physician During the Postoperative Period) is provided in the "Medicare Claims Processing Manual":

– CMS established modifier 79 to simplify billing for services provided to a patient by the same physician during the postoperative period that were unrelated to the original surgical procedure and not included in the payment for the surgical procedure. CMS established prepayment edits to detect separate billing of services that are included in the GSP; however, services billed with modifier 79 were excluded from those prepayment edits.

Make certain your billing staff reviews the payment guidelines for E/M services provided during the global period of surgery listed in this newsletter. These instructions can be found in the "Medicare Claims Processing Manual," Chapter 12, Section 40, which is available at http://www.cms.gov/manuals/downloads/clm104c12.pdf on the CMS website.

Recovery Audit Finding: Durable Medical Equipment (DME) While Patient Is Receiving Care from a Hospice Provider

Provider Types Affected: Durable Medical Equipment (DME) Suppliers

Problem Description:

Reviews by Recovery Auditors determined that suppliers are incorrectly billing and receiving payment for (DME, Prosthetics, Orthotics, and Supplies (DMEPOS) that should be paid by the hospice provider. Items or services related to a hospice terminal diagnosis provided during a hospice period are included in the hospice payment and not paid separately unless the GW modifier has been appended to the claim indicating services are not related to the hospice patient's terminal condition.

Guidance on How Providers Can Avoid These Problems:

✓Providers and suppliers should note that according to the "Medicare Claims Processing Manual," Chapter 20, Section 10.2, DMEPOS items provided to hospice patients are generally included in the payment for hospice services. Items of DMEPOS are covered by Medicare and paid in addition to the hospice payment only when those items or supplies are provided to the patient for treatment of a condition or illness not related to the patient's terminal illness. You may review the "Medicare Claims Processing Manual," Chapter 20, and Section 10.2, which is available at http://www.cms.gov/manuals/downloads/clm104c20.pdf on the CMS website.

✓The "Medicare Claims Processing Manual," Chapter 11, Section 40.2, states that carriers will deny claims for all other services related to the terminal illness furnished by individuals or entities other than the designated attending physician, who may be a Nurse Practitioner. Such claims include bills for any DME, supplies, or independently practicing speech-language pathologists or physical therapists that are related to the terminal condition. These services are included in the hospice rate and paid through the Fiscal Intermediary. You may review the "Medicare Claims Processing Manual," Chapter 11, Section 40.2, which is available at http://www.cms.gov/manuals/downloads/clm104c11.pdf on the CMS website.

✓The DMEPOS Supplier Manual Chapter 6 also indicates that any covered Medicare services not related to the treatment of the terminal hospice condition and which are furnished during a hospice election period may be billed to Medicare for payment. However these services should be coded with the GW modifier "service not related to the hospice patient's terminal condition."

✓Providers and suppliers should ensure that any supplies billed outside of the hospice are NOT related to the hospice diagnosis.

Recovery Audit Finding: Budesonide - Dose vs. Billed Units

Provider Types Affected: Durable Medical Equipment (DME) Suppliers

Problem Description:

Reviews by Recovery Auditors determined that quantities of budesonide greater than 62 units of service per month are being billed. The maximum amount of budesonide that Medicare will pay for is 62 units of service per month.

Covered Indications and Documentation Requirements:

Budesonide is a medication administered through inhalation via a nebulizer. Budesonide is supplied by the manufacturer as Pulmicort Respules® in 0.25, 0.5, and 1 mg unit dose vials. The Healthcare Common Procedure Coding System (HCPCS) code descriptor (J7626) indicates one Unit of Service (UOS) = up to 0.5 mg. Therefore, for the 0.25 mg or 0.5 mg unit dose forms, one UOS is billed for each vial dispensed. For the 1 mg unit dose form, one vial = two UOS.

The medical literature does not support the use of budesonide at a frequency greater than twice per day (regardless of whether 0.5 mg or 0.25 mg dose is used) or a cumulative dose greater than 1 mg/day. Therefore, according to the DME MAC's Local Coverage Determination (LCD) for Nebulizers, the maximum allowed amount is 62 units of service per month. Billing for quantities greater than 62 UOS per month will be denied as not medically necessary.

Guidance on How Providers Can Avoid These Problems:

When billing code J7626, suppliers should note the following examples:

Example 1: Dispensing 0.5 mg vials

Order is for budesonide 0.5 mg vials, administer 0.5 mg BID.

0.5 mg x 2x/day = 1 mg/day x 31 days = 31 mg/month

1 vial x 2x/day = 2 vials/day x 31 days = 62 UOS/month

Claim filed for 62 UOS of code J7626

Example 2: Dispensing 0.25 mg vials

Order is for budesonide 0.25 mg vials, administer 0.25 mg BID.

0.25 mg x 2x/day = 0.5 mg/day x 31 days = 15.5 mg/month

1 vial x 2x/day = 2 vials/day x 31 days = 62 UOS/month

Claim filed for 62 UOS of code J7626

Example 3: Dispensing 0.25 mg vials

Order is for budesonide 0.25 mg vials, administer 0.25 mg TID.

0.25 mg x 3x/day = 0.75 mg/day x 31 days = 23.25 mg

1 vial x 3x/day = 3 vials/day x 31 days = 93 UOS/month

Claim filed for 93 UOS of code J7626

In example 3, even though the total milligrams administered (23.25 mg/mo) is within the policy guidelines (31 mg/mo), the 93 units of service exceed the guidelines. If 0.75 per day is ordered, there is no medical necessity for three times per day administration. Administration of one 0.5 mg dose and one 0.25 dose per day would be appropriate. The excess units of service will be denied as not medically necessary.

For coverage of supplies and accessories pertaining to DME, you may review the "Medicare Benefit Policy Manual," Chapter 15 Section 110.3, which is available at http://www.cms.gov/manuals/Downloads/bp102c15.pdf on the CMS website.

Each DME MAC has issued an LCD for this drug. To view the LCDs, documentation requirements, and contractor articles on Budesonide (J7626) and Nebulizers, please visit the Medicare Coverage Database at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx on the CMS website. The articles demonstrate the proper coding and coverage of budesonide.

Each DME MAC has a supplier manual and they are available as follows:

Region A: NHIC http://www.medicarenhic.com/dme/dmemaca_sm_v004.pdf

Region B: NGS http://www.ngsmedicare.com/wps/wcm/connect/ce5d8d804529ceeba073a3cd1dd167d8/132_1210_JBSM_Composite.pdf?MOD=AJPERES

Region C: Cigna http://www.cignagovernmentservices.com/jc/pubs/supman/index.html

Region D: Noridian https://www.noridianmedicare.com/dme/news/manual/index.html

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