MEDICARE QUARTERLY PROVIDER COMPLIANCE NEWSLETTER

Guidance to Address Billing Errors

Volume 9, Issue 3

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Archive of previous Medicare Quarterly Provider Compliance Newsletters

INTRODUCTION

Learn about avoiding common billing errors and other erroneous activities when dealing with the Medicare Fee-For-Service (FFS) Program. This newsletter 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 Centers for Medicare & Medicaid Services (CMS) releases the newsletter on a quarterly basis. An archive of previously-issued newsletters, which includes keyword and provider-specific indices, is available on the CMS website.

COMPREHENSIVE ERROR RATE TESTING (CERT): INTRAVENOUS IMMUNE GLOBULIN (IVIG) FOR THE TREATMENT OF PRIMARY IMMUNE DEFICIENCY DISEASES IN THE HOME

Provider Types Affected: Durable Medical Equipment (DME) Suppliers and Physicians/Non-Physician Practitioners (NPPs) who write prescriptions for IVIG

Background: For dates of service on or after January 1, 2004, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (also known as the Medicare Modernization Act or MMA) provides coverage of IVIG for the treatment of primary immune deficiency diseases in the home.

The MMA defines "intravenous immune globulin" as an approved pooled plasma derivative for the treatment of primary immune deficiency disease. Medicare covers this benefit when:

- The patient has a diagnosis of a primary immune deficiency disease
- The IVIG is administered in the home of the patient
- The treating physician has determined that administration of the IVIG in the patient's home is medically appropriate.

Finding: Insufficient Documentation Causes Improper Payments
Improper payments for intravenous immune globulin were often due to insufficient documentation which means that something was missing from the submitted medical records to support payment for the service billed. Those claims with insufficient documentation lacked one or more of the following:

- Valid physician's order that includes all elements required by regulation, Medicare program manuals, and Medicare Administrative Contractor (MAC) specific guidelines

- Documentation to support that the service in the patient's home is medically appropriate
- Documentation to support medical necessity requirements for the service billed

Example of Improper Payments due to Insufficient Documentation - Missing valid physician order

A supplier billed for HCPCS J1569 (Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg) and in response to the CERT review contractor's request for documentation, submitted the following:

- An unsigned detailed order for the billed date of service
- Physician's clinical records documenting gamma globulin deficiency/immune deficiency syndrome being treated with the billed drug that also support that the service in the patient's home is medically appropriate
- Diagnostic test results
- Proof of delivery

An additional request for documentation returned a detailed written order that was signed after the claim was submitted for payment. There was no signed physician order prior to the claim submission as required per Medicare policy. The CERT review contractor scored this claim as an insufficient documentation error and Medicare recouped the payment from the provider.

Example of Improper Payments due to Insufficient Documentation - Missing physician documentation to support medical necessity

A supplier billed for HCPCS J1569 (Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg) and in response to the CERT review contractor's request for documentation, submitted the following:

- Proof of delivery
- A signed detailed order for the billed date of service
- Clinical notes that do not mention the beneficiary's diagnosis of a primary immune deficiency disease
- Infusion records for the billed date of service

An additional request for documentation returned no documentation. There was no documentation to support the need for the billed medication as required per Medicare policy. The CERT review contractor scored this claim as an insufficient documentation error and Medicare recouped the payment from the provider.

Example of Improper Payments due to Insufficient Documentation - Missing physician documentation to support medical necessity and to support that the service in the patient's home is medically appropriate

A supplier billed for HCPCS J1569 (Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg) and in response to the CERT review contractor's request for documentation, submitted the following:

- Proof of delivery
- Pharmacy labels

- A signed detailed order for the billed date of service
- Physician's preoperative examination note describing multiple medical problems; however, the note does not mention the beneficiary's diagnosis of a primary immune deficiency disease and does not support that the service in the patient's home is medically appropriate

An additional request for documentation returned duplicate documentation. There was no documentation to support the need for the billed medication as required per Medicare policy. The CERT review contractor scored this claim as an insufficient documentation error and Medicare recouped the payment from the provider.

Example of Improper Payments due to Insufficient Documentation - Missing physician documentation to support medical necessity and to support that the service in the patient's home is medically appropriate

A supplier billed for HCPCS J1569 (Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg) and in response to the CERT review contractor's request for documentation, submitted the following:

- Proof of delivery
- A signed detailed order for the billed date of service
- Supplier invoice with detailed description of billed service
- Clinical notes describing allergic rhinitis, chronic sinusitis, and asthma; however, the notes do not mention the beneficiary's diagnosis of a primary immune deficiency disease and do not support that the service in the patient's home is medically appropriate

An additional request for documentation returned no documentation. There was no documentation to support the need for the billed medication as required per Medicare policy. The CERT review contractor scored this claim as an insufficient documentation error and Medicare recouped the payment from the provider.

Resources:

You may want to review the following information to help avoid these billing errors:

- Section 1833 (e) (Insufficient Documentation) of the Social Security Act, which is available at https://www.ssa.gov/OP_Home/ssact/title18/1833.htm
- The relevant federal regulation in 42 CFR 424.5(a) (6) (Sufficient information), which is available at https://www.gpo.gov/fdsys/granule/CFR-2011-title42-vol3/CFR-2011-title42-vol3-sec424-5
- The Medicare Benefit Policy Manual, Chapter 15, Section 50.6 - Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
- The Medicare Claims Processing Manual, Chapter 17, Section 80.6 - Intravenous Immune Globulin, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf
- The Medicare Program Integrity Manual, Chapter 5, Section 5.2.3 - Detailed Written Orders, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c05.pdf
- The CERT provider website at https://certprovider.admedcorp.com/

- The CERT Program website, which is available at https://www.cms.gov/Research-Statistics-Data-and- Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/index.html
- Search for Local Coverage Determinations and Local Coverage Articles by your MAC for Intravenous Immune Globulin in the Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

RECOVERY AUDITOR FINDING: CORRECT REPORTING OF UNTIMED THERAPY UNITS

Provider Types Affected: Physicians, Non-Physician Practitioners (NPPs), Outpatient Hospitals, Comprehensive Outpatient Rehabilitation Facilities, and Skilled Nursing Facilities

Medicare Policy: Providers use untimed codes to bill for services that do not have specific time frames. No matter how long the evaluation or service, providers can bill only one unit of untimed codes for a patient per date of service with some exceptions. When you report service units for most untimed codes where the procedure is not defined as an add-on code or by a specific timeframe, enter a 1 in the 'units bill' column per date of service.

EXAMPLE: A beneficiary received a speech-language pathology evaluation that the provider billed with HCPCS "untimed" code 92521. Regardless of the number of minutes spent providing this service, the provider may only bill one unit of service for that same day.

Finding: Recovery Auditors are finding claims with more than one unit of service for the same day. The codes that they are finding with more than one unit billed per day include 92507, 92508, 92521, 92522, 92523, 92524, 92526, 92597, 92609, 97001, 97002, 97003, 97004, 97012, 97016, 97018, 97022, 97024, 97028, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, G0281, G0283, G0329.

Resources:

You may want to review the following information to help avoid these billing errors:

- The Medicare Benefit Policy Manual, Chapter 12, Section 40.4, which describes services provided in a Comprehensive Outpatient Rehabilitation Facility (CORF), is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c12.pdf
- Medicare Benefit Policy Manual, Chapter 15, Section 220.3 – Documentation Requirements for Therapy Services - contains information about untimed codes related to therapy services. This chapter is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
- Medicare Claims Processing Manual, Chapter 5, Section 20.2 – Reporting of Service Units with HCPCS - contains a section on timed and untimed codes related to outpatient rehabilitation services. This chapter is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf