MEDICARE QUARTERLY PROVIDER COMPLIANCE NEWSLETTER

Guidance to Address Billing Errors

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PRINT-FRIENDLY VERSION

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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 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.

Physicians

Skilled Nursing Facility

Durable Medical Equipment Suppliers

Hospitals

COMPREHENSIVE ERROR RATE TESTING (CERT): OBSERVATION AND INPATIENT HOSPITAL CARE

PHY H

Provider Types Affected: Physicians and Hospitals

Background: When a patient receives observation care for a minimum of 8 hours, but less than 24 hours, and is discharged on the same calendar date, providers should use the Healthcare Common Procedure Coding System (HCPCS) code range of 99234 to 99236 to bill for observation or inpatient care services, including admission and discharge services.

To meet the requirements for billing observation or inpatient care services, HCPCS code 99234 (Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity) documentation in the medical record must include the three key components and:

- Documentation stating the stay for observation care or inpatient hospital care involves 8 hours, but less than 24 hours;
- Documentation identifying the billing physician was present and personally performed the services; and
- Documentation identifying the order for observation services, progress notes, and discharge notes were written by the billing physician.

Description of Special Study: The CERT review contractor conducted a special study of claims with lines billed with HCPCS code 99234 submitted from April through June 2017. When CERT reviews a claim, all lines submitted on the claim undergo medical record review.

Finding: Insufficient Documentation Causes Most Improper Payments
Most improper payments in this special study were due to insufficient documentation which means that something was missing from the submitted medical records to support payment for the service billed. Most HCPCS code 99234 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 MAC specific guidelines
- Documentation to support the services were provided or other documentation required for payment of the code
- Hospital record
- A properly authenticated record; when a signature is missing or illegible, a signature log to support a clear identity of an illegible signature or an attestation for documentation received without a signature is required

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

A physician billed for HCPCS 99234 and in response to the CERT review contractor's request for documentation, submitted the following:

- A discharge summary note for the billed Date of Service (DOS)

An additional request for documentation returned a history and physical note for the billed DOS. There was no billing physician's orders to support the observation services billed as Medicare policy requires. The CERT review contractor scored this claim as an insufficient documentation error and the payment was recouped from the provider.

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

A physician billed for HCPCS 99234 and in response to the CERT review contractor's request for documentation, submitted the following:

- The billing provider's authenticated medical oncology note for the billed DOS with no mention of observation services or care

An additional request for documentation returned duplicate copies of the billing provider's medical oncology note. There was no billing physician's orders to support the observation services billed or documentation to support the need for the observation services as Medicare policy requires. The CERT review contractor scored this claim as an insufficient documentation error and the payment was recouped from the provider.

Example of Improper Payments due to Insufficient Documentation - Missing signature

A physician billed for HCPCS 99234 and in response to the CERT review contractor's request for documentation, submitted the following:

- An unauthenticated progress note for the billed DOS
- An unauthenticated progress note dated one day after the billed DOS
- An authenticated discharge summary dated after the DOS

An additional request for documentation returned transfer orders and duplicate progress notes that had been altered to include the physician's signature. The documentation submitted was missing a signature attestation per Medicare guidelines to support the entries made on the submitted unauthenticated progress note for the billed DOS. Providers should not add late signatures to the medical record, beyond the short delay that occurs during the transcription process, but instead should make use of the signature authentication process. The CERT review contractor scored this claim as an insufficient documentation error and the payment was recouped from the provider.

Example of Improper Payments due to Incorrect Coding - Billed service incorrectly coded

A physician billed for HCPCS 99234 and in response to the CERT review contractor's request for documentation, submitted the following:

- An authenticated progress note that exceeded the required three key components for HCPCS code 99234

The submitted documentation supported a comprehensive history, comprehensive exam, and moderate complex medical decision making, for a code change from the billed HCPCS code of 99234 to HCPCS code 99235. The CERT review contractor scored this claim as an incorrect coding error with a corrected payment made to 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 Claims Processing Manual, Chapter 12, Section 30.6.8 - Payment for Hospital Observation Services and Observation or Inpatient Care Services (Including Admission and Discharge Services), which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
- The Medicare Program Integrity Manual, Chapter 3, Sections 3.3.2.4 (Signature Requirements) and 3.3.2.4.C (Signature Attestation Statement), which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.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

RECOVERY AUDITOR FINDING - A REMINDER: DURABLE MEDICAL EQUIPMENT (DME) SUPPLIERS BILLING FOR DME FOR BENEFICIARIES IN A MEDICARE INPATIENT STAY

DMES SNF

Provider Types Affected: Suppliers and physicians furnishing DME to patients in an inpatient facility (hospital or Skilled Nursing Facility (SNF))

Problem Description: A supplier (includes physician furnishing DME) may deliver a DME, prosthetics, or orthotics (DMEPOS) item to a patient in a hospital or SNF for the purpose of fitting or training the patient in the proper use of the item. This may be done up to 2 days prior to the patient's anticipated discharge to their home. The supplier should bill the date of service on the claim as the date of discharge and shall use the Place of Service (POS) as 12 (patient's home). The item must be for subsequent use in the patient's home. No billing may be made for the item on those days the patient was receiving training or fitting in the hospital or nursing facility.

Medicare Policy: Medicare policy regarding billing for such DMEPOS items is available in the Medicare Claims Processing Manual, Chapter 20, Sections 110.3, 211, and 212. Specific policy related to pre-discharge delivery of DMEPOS is that Medicare will presume that the pre-discharge delivery of DME, a prosthetic, or an orthotic (hereafter "item") is appropriate when all the following conditions are met:

1. The item is medically necessary for use by the beneficiary in the beneficiary's home.
2. The item is medically necessary on the date of discharge, for example, there is a physician's order with a stated initial date of need that is no later than the date of discharge for home use.
3. The supplier delivers the item to the beneficiary in the facility solely for the purpose of fitting the beneficiary for the item, or training the beneficiary in the use of the item, and the item is for subsequent use in the beneficiary's home.
4. The supplier delivers the item to the beneficiary no earlier than 2 days before the day the facility discharges the beneficiary.
5. The supplier ensures that the beneficiary takes the item home, or the supplier picks up the item at the facility and delivers it to the beneficiary's home on the date of discharge.
6. The reason the supplier furnishes the item is not for the purpose of eliminating the facility's responsibility to provide an item that is medically necessary for the beneficiary's use or treatment while the beneficiary is in the facility. Such items are included in the Diagnostic Related Group (DRG) or Prospective Payment System (PPS) rates.

7. The supplier does not claim payment for the item for any day prior to the date of discharge.
8. The supplier does not claim payment for additional costs that the supplier incurs in ensuring that the item is delivered to the beneficiary's home on the date of discharge. The supplier cannot bill the beneficiary for redelivery.
9. The beneficiary's discharge must be to a qualified place of service (such as home, custodial facility), but not to another facility (inpatient or skilled nursing) that does not qualify as the beneficiary's home.

Finding: The Recovery Auditor previously performed an automated review of selected claims from the last 3 years in which DMEPOS was billed. (See the April 2018 newsletter, pages 7 and 8 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-ICN902283.pdf. The specific HCPCS codes reviewed were E0100 - E8002, K0001 – K0899, L0112 – L4631, V2020 – V2786, A4206 – A9999, B4034 – B9999, and relevant J and Q codes. In addition to looking at such DMEPOS claims, the Recovery Auditor looked for Types of Bills 011X, 012X, 018X, 021X, or 022X, which would show a beneficiary inpatient stay for the date of service on the DMEPOS claim. As a reminder, the Recovery Auditor did identify claims for such codes with a date of service that fell during a covered inpatient or SNF stay. Recovery Auditors continue to detect problems related to this issue and asked that this issue be included in this newsletter as a reminder. Thus, suppliers should remember the rules for providing DMEPOS items to a beneficiary during a stay that is covered by a DRG or PPS payment as noted above and in the Medicare Claims Processing Manual, Chapter 20, Section 110.3.

Resources:

You may want to review the following information to help avoid medical necessity errors:

- The Medicare Claims Processing Manual, Chapter 20, Section 110.3, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf.