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CMS Issues Its Second Billing Compliance Newsletter for Fee for Service Providers and Suppliers

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In an earlier issue of *Payment Matters* we advised readers that the Centers for Medicare and Medicaid Services (CMS) had commenced publishing a quarterly newsletter identifying billing issues based on problems identified in reviews conducted by Medicare Claims Processing Contractors, Recovery Audit Contractors, Program Safeguard Contractors, Zone Program Integrity Contractors, and other governmental organizations, such as the Office of Inspector General (OIG). The newsletter is intended for fee for service providers and suppliers, such as hospitals, physicians, skilled nursing facilities, labs, ambulance companies, and durable medical equipment, prosthetics, orthotics, and supplies suppliers. CMS recently issued its second compliance newsletter [PDF], which addresses seven billing issues that are discussed below. According to CMS:

> 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.

Inpatient Hospitals

Tracheostomy – Incorrect Coding

Medicare Recovery Audit Contractors (RACs) have identified hospitals that are inappropriately billing for the creation of a new tracheostomy, when services performed only involve revising an existing tracheostomy. MS DRGs 004, 011, 012, and 013 were validated. CMS offered tips for identifying the issue and citations to CMS Manual and other guidance such as Medicare Program Integrity Manual, Chapter 6, Section 6.5.3 A-C and 6.5.4, Medicare Claims Processing Manual, Chapter 3 (Inpatient Hospital Billing), Section 20 (Payment Under Prospective Payment System (PPS) Diagnosis Related Groups (DRGs)), Medicare Benefit

Policy Manual, Chapter 1, Section 10 and ICD-9-CM Official Guidelines for Coding and Reporting.

Excisional Debridement – Incorrect Coding

Medicare RACs found that providers were incorrectly coding non-excisional debridement as excisional debridement. Validation of the following MS DRGs was conducted: 463, 464, 465, 573, 574, 575, 901, 902, and 903. CMS offered compliance tips and cited to the following: Medicare Program Integrity Manual, Chapter 6, Sections 6.5.3A-C and 6.5.4, Medicare Claims Processing Manual, Chapter 3, Section 20, and ICD-9 Official Guidelines for Coding and Reporting and other resources.

Physicians

Not a New Patient – Incorrect Coding

Medicare RACs reported 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.

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. CMS advised that “[a]n 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.’” CMS cited Medicare Claims Processing Manual, Chapter 12, Section 30.6.7 and MLN Matters® Article MM4032.

Evaluation and Management (E/M) Billing During the Global Surgery Period
RACS 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. CMS discussed the proper use of Modifiers 24, 25, 57, and 79, and cites to the Medicare Claims Processing Manual, Chapter 12, Section 40 for further guidance.

Outpatient Providers and Physicians

Chemotherapy Administration and Non-Chemotherapy Injections and Infusions – Incorrect Coding
RACs found that providers were incorrectly coding Chemotherapy Administration and Non-chemotherapy Injections and Infusions more than once per day without an appropriate modifier. The problem involved claims for HCPCS Codes 96413, 90765, 96365, 90769, 96369 and American Medical Association (AMA) Coding Modifier 59. CMS cited to the Medicare Claims Processing Manual, Chapter 12, Section 30.5 for further guidance.

DMEPOS Suppliers

Durable Medical Equipment (DME) While Patient Is Receiving Care from a Hospice Provider
According to CMS, RACs determined that suppliers incorrectly billed and received 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 terminal illness. CMS cited to Medicare Claims Processing Manual, Chapter 20, Sections 10.2 and Chapter 11, Section 40.2 and to the DMEPOS Supplier Manual Chapter 6.

Budesonide - Dose vs. Billed Units

CMS reported that RACs determined that quantities of budesonide greater than 62 units of service per month were being billed. The maximum amount of budesonide that Medicare will pay for is 62 units of service per month. CMS offered tips and guidance on addressing this issue and cited to Medicare Benefit Policy Manual, Chapter 15, Section 110.3. CMS stated that each DME Medicare Audit Contractor (MAC) has issued a local coverage determination (LCD) for this drug which can be found on the Medicare Coverage Database.

Ober Kaler's Comments

Fee for service providers are advised to be attentive and ensure billing staff reviews this guide and the provisions cited in the guide, as well as monitor ongoing advice from CMS, its contractors and the OIG on billing issues that the government is examining.