Medicare Provider Compliance Newsletter

Guidance to Address Billing Errors

Volume 13, Issue 1

Table of Contents

Learn how to avoid common billing errors and other erroneous activities when working with the Medicare Fee-for-Service (FFS) Program. This newsletter includes guidance to help you address and avoid current top mistakes.

The Medicare FFS Program processes more than 1 billion claims each year. Medicare Administrative Contractors (MACs) process these claims and make payments to more than 1 million health care professionals based on Medicare regulations. MACs also provide education on how to submit accurately coded claims.

Despite actions to prevent improper payments, it's impossible to prevent them all due to the large volume of claims. The Medicare Learning Network's® Medicare Provider Compliance Newsletter helps you understand the latest findings by MACs and other contractors, like Recovery Auditors and the CERT Review Contractor. Other government organizations, like the Office of the Inspector General (OIG), also conduct reviews and identify issues.

Physicians

Non-Physician Practitioners

Outpatient Hospital

Ambulatory Surgical Center

Professional Services

COMPREHENSIVE ERROR RATE TESTING (CERT): HOSPITAL OUTPATIENT SERVICES[1]

PHY NPPs

Provider Types Affected:

- Physicians
- Non-Physician Practitioners (NPPs)
- Providers who bill 12x—19x

Background: Hospitals provide 2 types of services to outpatients — diagnostic services and other services that aid the physician in treating the patient. Covered services include, but are not limited to, the following:

- Medication administration
- Laboratory and other diagnostic testing
- Outpatient surgical procedures
- Therapy services

Description: According to the 2022 Medicare Fee-for-Service Supplemental Improper Payment Data report, the projected improper payment amount for hospital outpatient services[1] was $4.4 billion, resulting in an improper payment rate of 5.4%. Insufficient documentation accounted for 91% of the hospital outpatient improper payments, which means that something was missing from the submitted medical records to support payment for the services billed. Hospital outpatient claims with insufficient documentation errors most commonly were due to a missing order, missing provider's intent to order, or inadequacies (that is, required elements are missing) with an order.

Example of Improper Payments Due to Insufficient Documentation — Missing Order or Provider's Intent to Order

A provider bills for a portable chest X-ray they performed during an emergency department (ED) encounter. In response to the CERT review contractor's request for documentation, the provider submits this documentation:

- A physician's ED visit note stating a history of Chronic Obstructive Pulmonary Disease (COPD) with active dizziness and increasing shortness of breath
- Portable chest X-ray report
- Nursing records and notes
- Pre-arrival summary
- Ambulance report

[1]Hospital Outpatient services are further defined as all services that are billed with 12x through 19x — in other words, Hospital OPPS (Outpatient Prospective Payment System, laboratory, and others).

What Documentation Was Missing?

The documentation didn't include an order or intent to order a portable chest X-ray.

What Happens Next?

The CERT review contractor finalizes the claim as an insufficient documentation error, and the Medicare Administrative Contractor (MAC) recoups payment.

Example of Improper Payments Due to Insufficient Documentation — Inadequate Order

A hospital bills for a lipid panel and submits this documentation in response to the CERT review contractor's request:

- Lipid panel order that's missing authentication
- Lipid panel results
- Cardiology history and physical documenting multiple drug reactions to statins

What Documentation Was Missing?

The lipid panel order wasn't signed, and there was no intent to order the billed service noted within the authenticated history and physical.

What Happens Next?

The CERT Review Contractor finalizes the claim as an insufficient documentation error, and the MAC recoups payment.

Resources

Use these resources to help you avoid errors when billing hospital outpatient services:

- 42 CFR 424.5(a)(6)
- 42 CFR 410.32(a)
- CMS Hospital Outpatient Prospective Payment System
- Medicare Benefit Policy Manual, Chapter 6, Sections 20 and 20.5.3
- Medicare Benefit Policy Manual, Chapter 15, Section 80.6.1
- Medicare Claims Processing Manual, Chapter 4, Section 20.1
- Medicare Program Integrity Manual, Chapter 3, Sections 3.3.2.4 and 3.6.2.2
- Social Security Act 1862(a)(1)(A)

RECOVERY AUDITOR REVIEW 0210: HYPOGLOSSAL NERVE STIMULATION FOR OBSTRUCTIVE SLEEP APNEA: MEDICAL NECESSITY AND DOCUMENTATION REQUIREMENTS

Provider Types Affected:

- Outpatient Hospitals
- Ambulatory Surgical Centers
- Professional Services

Problem Description: Providers should know the documentation and medical necessity criteria when billing for hypoglossal nerve stimulation (HNS) to treat moderate to severe obstructive sleep apnea (OSA). The Recovery Audit Contractor (RAC) reviews the medical record to determine if HNS meets Medicare coverage criteria, applicable coding guidelines, and is medically reasonable and necessary.

Background: The CPT code for this review is 64582 (Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array)

Recommendations

- Follow documentation and medical necessity guidelines when billing for HNS to prevent improper payments for HNS claims. Review the coverage indications, limitations, and medical necessity requirements in the Local Coverage Determinations (LCDs) and Local Coverage Articles (LCAs) on your MAC's website.
- Respond to RAC review requests promptly and completely. Submit all documentation to support your claim for HNS.

Resources

Use these resources to help you avoid errors when billing HNS:

- Billing and Coding: HNS for Treatment of OSA
- LCD L38276
- Medicare FFS Recovery Audit Program
- NCD Sleep Testing for OSA