

Medicare B Update!

A Newsletter for Connecticut and Florida Medicare Part B Providers

Highlights In This Issue...

Claims, Appeals, and Hearings

<i>Change Payment Floor Date for Paper Claims</i>	11
<i>Modifier 50 - Bilateral Procedures</i>	13
<i>Moving to Paperless Claim Environment</i>	13
<i>Quarterly Update to CCI Edits, Version 12.1</i>	9

HIPAA—The Health Insurance Portability and Accountability Act

<i>MSP Claims Must Be Submitted Electronically</i>	77
<i>Medicare Remittance Easy Print (MREP)</i>	81
<i>Attestation Form for Conducting Real Time Eligibility Inquiries with Medicare</i>	86

General Information

<i>Revised CNS-1500 Claim Form</i>	89
<i>National Provider Identifier</i>	90
<i>Medicare to Stop Mailing SPR for Providers/Suppliers Receiving an Electronic Remittance Advice</i>	95
<i>Appeals of Claims Decisions; Administrative Law Judge; Departmental Appeals Board; U.S. District Court Review</i>	102

General Medical Review

<i>Information Applied to both Connecticut and Florida</i>	142
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Connecticut Medical Review

<i>Corrected, Revised, and Additional Information on LCDs</i>	149
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Florida Medical Review

<i>Corrected, Revised, and Additional Information on LCDs</i>	156
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Features

Connecticut and Florida		
A Physician's Focus	3	General Information
About the <i>Update!</i>	7	
Claims		
	11	Medical Review
Coverage/Reimbursement ..	15	General
HIPAA and EMC	76	Connecticut Only
		Medical Review
		149

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The Medicare B Update! should be shared with all health care practitioners and managerial members of the provider/supplier staff. Publications issued beginning in 1997 are available at no cost from our provider education Web sites: <http://www.connecticutmedicare.com> and <http://www.floridamedicare.com>.

Routing Suggestions:

- Physician/Provider
- Office Manager
- Billing/Vendor
- Nursing Staff
- Other _____



A PHYSICIAN'S FOCUS

Requirements for the Payment of Medicare Claims—A Selection of Some Important Criteria



In addition to national and local coverage determinations (NCDs and LCDs), there are certain principles that apply to all Medicare claims. These are rooted in the Medicare laws and regulations. By drawing the attention of our provider community to these topics, we anticipate reducing the claim payment error rate and reimbursing for medically necessary services correctly and expeditiously. This is not an all-inclusive list, but it does represent frequent observations from our Medical Review and Medical Policy departments. The focus of this article is on professional services that are usually but not always billed to the carrier (Part B funds) as opposed to the fiscal intermediary (FI – Part A and B funds). However, the principles apply to FI services unless specific differences are noted in the Medicare manuals. We hope that this publication will be useful to our providers and their teams by facilitating the correct filing of claims and the submission of supportive information.

Documentation

General Information

Below are some key points:

- Medicare expects the documentation to be generated at the time of service or shortly thereafter. Delayed entries within a reasonable time frame (24-48 hrs.) are acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service.
- The medical record cannot be altered. Errors must be legibly corrected so that the reviewer can draw an inference as to their origin. These corrections or additions must be dated, preferably timed, and legibly signed or initialed.
- Every note must stand alone, i.e., the performed services must be documented at the outset. Delayed written explanations will be considered. They serve for clarification only and cannot be used to add and authenticate services billed and not documented at the time of service or to retrospectively substantiate medical necessity. For that, the medical record must stand on its own with the original entry corroborating that the service was rendered and was medically necessary.
- If the provider elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter must be documented in the medical record. Generally, the time must be documented when billing for all time-based codes, such as critical care, prolonged services, hospital discharge services, and others.
- All entries must be legible to another reader to a degree that a meaningful review may be conducted. All notes should be dated, preferably timed, and signed by the author. In the office setting, initials are acceptable as long as they clearly identify the author. If the signature is not legible and does not identify the author, a printed version should be also recorded.

Responding to Additional Documentation Request Letters and Requests from the Comprehensive Error Rate Testing Contractor

Although the terminology of these letters may vary, it is important to send all information that will support the claim. For non-laboratory services, this is the billing provider's responsibility, regardless if she or he has created it. For example, when seeking reimbursement for a diagnostic test, the performing (billing) provider should not only submit the report but also the order and the referring provider's office notes that document the medical necessity for the study. If the information received fails to support the coverage or coding of the claim, in full or in part, the contractor must deny the claim, in full or in part (CMS Online Manual System, Pub. 100-8, Program Integrity Manual, Chapter 3, Section 3.4.1.2A).

There are situations where test reports or other elements of the documentation are housed at a different location from the performing provider's office, for instance an EKG or X-ray read in the hospital. Because it is the performing provider who is required to submit this documentation upon request, it would be best practice if providers kept a copy of this information in their records so that it is readily available. This is a very important issue, as it continues to generate a high error rate in CMS' CERT (comprehensive error rate testing) program and results in numerous recoupments of payments already made.

*Requirements for the Payment of Medicare Claims—A Selection of Some Important Criteria (continued)***Cloning of Medical Notes**

Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.

Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

Evaluation and Management Coding**Procedure Code/Diagnosis Code Linking**

It is not enough to link the procedure code to a correct, payable ICD-9-CM code. The diagnosis or clinical signs/symptoms must be present for the procedure to be paid.

Volume of Documentation vs. Medical Necessity

The Social Security Act, Section 1862 (a)(1)(A) states: “No payment will be made ... for items or services ... not reasonable and necessary for the diagnosis or treatment of an injury or illness or to improve the functioning of a malformed body member.” This medical reasonableness and necessity standard is the overarching criterion for the payment for all services billed to Medicare. Providers frequently “over document” and consequently select and bill for a higher-level E/M code than medically reasonable and necessary. Word processing software, the electronic medical record, and formatted note systems facilitate the “carry over” and repetitive “fill in” of stored information. Even if a “complete” note is generated, only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate level of an E/M service. Information that has no pertinence to the patient’s situation at that specific time cannot be counted.

Shared Visits

Shared visits with non-physician providers (NPPs) may be reported as one visit, if each provider sees the patient separately and each documents separately. Each component of the visit must be medically necessary.

In the office/clinic setting:

- Providers may bill under the physician’s provider identification number (PIN), if all “incident to” requirements are met (follow-up visit, direct supervision, etc.).
- The service must be billed under the non-physician provider’s PIN if any of the “incident to” requirements are not met (example: new patient and/or physician not in the office suite).

In the hospital inpatient/outpatient/ER setting:

- Providers may bill under the physician’s or NPP’s PIN if the physician provides any face-to-face portion of the E/M encounter with the patient.
- The services must be billed under the NPP’s PIN if there is no face-to-face encounter by the physician.

The medical necessity of a service is the overarching criterion of payment. All interventions must be aimed at benefiting the patient and not only satisfying a billing requirement. It must be apparent that the face-to-face encounter with the physician is medically necessary and benefits the patient (impacts evaluation, treatment, and outcome). Shared visits cannot be reported in the skilled nursing facility (SNF) or nursing facility (NF) settings.

Scribing

If a nurse or non-physician practitioner (PA, NP) acts as a scribe for the physician, the individual writing the note (or history or discharge summary, or any entry in the record) should note “written by xxxx, acting as scribe for Dr. yyyy.” Then, Dr. yyyy should co-sign, indicating that the note accurately reflects work and decisions made by him/her.

It is inappropriate for an employee of the physician to make rounds at one time and make entries in the record, and then for the physician to make rounds several hours later and note “agree with above,” unless the employee is a licensed, certified provider (PA, NP) billing Medicare for services under his/her own name and number.

Record entries made by a “scribe” should be made upon dictation by the physician, and should document clearly the level of service provided at that encounter. This requirement is no different from any other encounter documentation requirement. Medicare pays for medically necessary and reasonable services, and expects the person receiving payment to be the one delivering the services and creating the record. There is no carrier Part B “incident to” billing in the hospital setting (inpatient or outpatient). Thus, the scribe should be merely that, a person who writes what the physician dictates and does. This individual should not act independently, and there is no payment for this activity.

It is acceptable for a physician to use a scribe, but current documentation guidelines must be followed. The physician is ultimately accountable for the documentation, and should sign and note after the scribe’s entry the affirmation above that the note accurately reflects work done by the physician.