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# High-Risk Areas In Medicare Billing

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August 2009

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## CURRENT DEVELOPMENTS

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***CMS has released the final Inpatient Prospective Payment System rule for FY 2010.*** A summary of the rule begins on p. 5. One item in the rule is a discussion of the revised cost report, and the rule says that a draft of the revised report, CMS-2552-10, is available at [www.cms.hhs.gov/](http://www.cms.hhs.gov/)

PaperworkReductionActof1995, under “PRA Listing.” The revised cost report will be used for periods beginning on or after Feb. 1, 2010.

***In line with the CMS recovery audit contractor (RAC) phase-in strategy, two of the RACs have posted the first issues that they will be targeting in the reviews.*** The issues are being audited by Connolly Consulting Associates, the RAC for Region C, which covers the Deep South, Texas, Oklahoma, and Colorado, and the Connolly posting indicates that South Carolina will be the first state audited for these issues. HealthDataInsights, the RAC for Region D, which includes 17 states and three territories — the Northwest (including Alaska), Idaho, Montana, Wyoming, Nebraska, Utah, Arizona, Nevada, California, Hawaii, the Midwest states of Iowa, Idaho, Kansas, Missouri North Dakota, South Dakota and three territories, Guam, American Samoa, Northern Marianas, indicates that all of its states will be under review.

All of the items on the list are errors affect hospital outpatient departments and physicians.

The first batch — seven in all — are automated reviews, but two of the targets areas likely foreshadow more complex reviews in the future. Here are the seven approved issues with analysis and advice. Note that modifiers are not under review in this stage of the audits:

(1) *IV hydration therapy* (based on the definition of CPT code 90760, excluding claims with modifier 59). The maximum number of units billed should be one per patient per date of service. In January 2009, CPT code 96360 replaced 90760.

(2) *Blood transfusions* (CPT codes 36430, 36440, 36450, and 36455, excluding claims with modifiers). Transfusions should be billed as one per session, regardless of the number of units transfused on that date of service.

(3) *Untimed codes* (CPT codes excluding modifiers KX and 59), where the procedure is not defined by a specific time frame. This review appears aimed at outpatient rehabilitation (physical, speech, and occupational therapy). According to Trans. 1019, CR 5253 (Aug. 3, 2006), when reporting service units for untimed HCPCS codes, providers enter the number one in the field labeled “units.” Units are reported “based on the number of times the procedure is performed, as described in the HCPCS code definition (often once per day),” the transmittal states. For example, when a Medicare patient receives a speech-language pathology evaluation repre-

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sented by untimed code 92506, the service is billed as one unit, regardless of how long it took.

(4) *Once-in-a-lifetime procedures.* These are procedures, such as tonsillectomies and appendectomies, that are only performed once per patient per lifetime.

(5) *Pediatric codes exceeding age parameters* (newborn/pediatric codes being applied/billed for patients who exceed the age limit defined by the CPT code).

(6) *Bronchoscopy services* (CPT codes 31625, 31628, and 31629, excluding claims with modifier 59). No more than one unit of service should be billed per patient per date of service.

(7) *Pegfilgrastim* (also known as Neulasta), injection, 6 mg. (HCPCS code J2505). Providers should bill the code at one unit per patient per date of service. According to Medicare Trans. 949, CR 4380 (May 12, 2006), CMS has determined that some hospital outpatient providers bill multiple units of J2505 per date of service.

“Many of the providers billing multiple units of J2505 were consistently billing 6 units per date of service, indicating that 36 mg. of Pegfilgrastim were given. The usual dose of Pegfilgrastim is 6 mg.,” the transmittal says. To reduce errors in this area, CMS reiterated that HCPCS code J2505 is defined as 6 mg. of Pegfilgrastim. “This is usually administered via a pre-filled syringe of 0.6 ml, which is equivalent to 6 mg.. Providers should ensure they are billing for the number of multiples of 6 mg. administered rather than the number of mgs. or mls. administered.”

After these straightforward reviews, the RACs will conduct DRG validations, complex coding

reviews, and medical necessity reviews for durable medical equipment.

For list of issues, go to [www.connollyhealthcare.com/RAC/Pages/cms\\_RAC\\_Program.aspx](http://www.connollyhealthcare.com/RAC/Pages/cms_RAC_Program.aspx) or <http://racinfo.healthdatainsights.com/Public/NewIssues.aspx>.

***CMS has been issuing transmittals addressing the coding and billing requirements for services rendered to Medicare beneficiaries during an emergency or disaster, such as hurricanes, floods, and tornadoes.*** In Trans. 1784, it announces a new chapter, Chapter 38, in the Medicare Claims Processing Manual, that will contain all standing policies and procedures related to disasters and other public emergencies. It also clarifies the policy on use of the modifier CR and condition code DR and makes their use mandatory, rather than discretionary, when a service is affected by an emergency or disaster and Medicare payment for such service is conditioned on the presence of a “formal waiver.” The transmittal defines a “formal waiver.”

The DR condition code is used for institutional billing only at the claim level when all of the services/items billed on the claim are related to the emergency/disaster.

The CR modifier is used for Part B items and services only but may be used in either institutional or non-institutional billing.

If either the contractor or CMS determine that use of the code is needed to efficiently and

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effectively process claims or to otherwise administer the Medicare fee-for-service program, they also may mandate use of the code/modifier. Trans. 1784, CR 6451 (July 31; eff./ impl. Aug 31, 2009).

***As of Jan. 1, 2010, facilities will have two new point of origin (formerly source of admission) codes to enter on the UB-04 (in FL 15 or its electronic equivalent).***

◆ E – Transfer from Ambulatory Surgical Center:

— *Inpatient:* This patient was admitted to this facility as a transfer from an ambulatory surgery center.

— *Outpatient:* The patient was referred to this facility for outpatient or referenced diagnostic services from an ambulatory surgery center.

◆ F – Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program:

— *Inpatient:* The patient was admitted to this facility as a transfer from hospice.

— *Outpatient:* The patient was referred to this facility for outpatient or referenced diagnostic services from a hospice.

Trans. 1775, CR 6478 (July 24, 2009; eff. Oct. 1, 2007; impl. Jan. 4, 2010).

***CMS issued three transmittals at the end of July affecting critical access hospitals (CAHs).*** The first two affect Method II CAHs; the last implements a Medicare Improvements for Patients and Providers Act (MIPPA) provision.

*Trans. 1777* reviews the billing requirements, including use of modifiers, and payment rules for bilateral procedures performed in a Method II CAH. Medicare will pay for bilateral procedures performed during the same operative session, but the payment differs based on whether the procedure is a bilateral one that carries a payment policy indicator of “1” in the Medicare physician fee schedule (MPFS). Payment policy indicator “1” identifies procedures that are paid at the lower of actual charges or 150% of the Medicare physician fee schedule. Other procedures that are bilateral but carry the payment indicator “3” are paid at the lesser of actual charges or 100% of the MPFS. In both instances, the procedure is billed with modifier 50 and

should show one unit of service. With implementation of the January 2010 Integrated Outpatient Code Editor (IOCE), CAH claims submitted on TOB 85X with revenue codes 96X, 97X or 98X for bilateral procedures will be returned to provider (RTP) if the following are present on the claim:

◆ HCPCS/CPT code with modifier 50

— Bilateral payment policy indicator of ‘1’ or ‘3’ (from the Medicare physician fee schedule)

— More than one service unit on the same line

◆ HCPCS/CPT code with modifier 50

— Payment policy indicator 0, 2, or 9

◆ HCPCS/CPT code with modifier LT or RT (either on same or separate lines)

— Payment policy indicator 1 or 3

Note that Appendix A of the quarterly Integrated Outpatient Code Editor illustrates the logic for bilateral claims and the claim disposition. Trans. 1777, CR 6526 (July 24, 2009; eff. Jan. 1, 2008; impl. Jan. 4, 2010).

*Trans. 1781* sets out the billing and payment rules for co-surgeons who have assigned their billing rights to the Method II CAH, as well as the disposition of the claims. The transmittal explains when Medicare will pay for co-surgeons during surgery and the requirements that must be met. To qualify as co-surgery, the procedure must require the skills of two physicians, each with different specialties. If a procedure qualifies for co-surgery it will carry the MPFS payment policy indicator “1” or “2,” and depending on the indicator, the payer will request different supporting documentation. A claim for co-surgery must have modifier 62 attached to the procedure code. If the claim reports the two surgeons on separate lines, the procedure code must be the same and the modifier 62 attached to both codes. If the payment indicator is “1,” the CAH must issue an ABN or risk nonpayment. Payment is the lesser of the actual charge or 62.5% of the MPFS, and the CAH is paid 115% of the lesser amount. Trans. 1781, CR 6319 (July 29, 2009; eff. Jan. 1, 2008; impl. July 6, 2009).

*Trans. 1782* implements section 148 of MIPPA. This section requires Medicare to pay CAHs 101% of reasonable cost for outpatient clinical diagnostic laboratory tests even if the patient is not physically present in the CAH at the time the specimen is collected. However, the patient must

have received outpatient services at the CAH on the same day or the specimen must be collected by a CAH employee. If the individual is physically present in the CAH or a provider-based facility of the CAH, then the patient does not need to meet these conditions. Note that the Inpatient Prospective Payment System final rule also finalized this policy. Trans. 1782, CR 6395 (July 30; eff. July 1; impl. July 6, 2009).

***CMS has announced the laboratory travel allowance for specimen collection for 2009, updating Pub. 100-04, Ch. 16, sec. 60.2.*** The amounts are effective Jan. 1, 2009, but not available for processing until Oct. 1, 2009. There are two options for the travel allowance: \$1.00 per mile for trips that exceed 20 miles to the patient's home or nursing facility. This per-mile allowance is billed with P9603. The flat-rate amount is \$10 per trip and billed with P9604. If multiple collections are drawn during the same trip and some of the draws are from non-Medicare patients, the allowance is prorated. Payers also may choose which method to use, and the transmittal notes that because audits found abuse of the per-mile method, some payers elected to use the flat-rate basis only. Trans. 1790, CR 6524 (Aug. 7; eff. Jan. 1; impl. Oct. 5, 2009).

***Beginning in 2010, the Medicare claims processing system will be able to accept fractional mileage for ambulance trips in increments of 1/10<sup>th</sup> of a mile billed on a CMS-1500 paper claim or ANSI X12N 837P electronic claim.*** This policy does not apply to hospital-based ambulance services. Currently, ambulance suppliers round the mileage up or down, and this creates the potential for overpayments, as well as audit issues. Suppliers will report fractional mileage units rounded to the nearest tenth of a mile for all claims for mileage totaling up to, but not including, 100 covered miles. For trips totaling 100 covered miles and greater, suppliers continue to report mileage rounded to the nearest whole number mile. If the trip is less than a mile, the mileage is reported with a "0" before the decimal, e.g., 0.9. Trans. 1787, CR 6543 (July 31, 2009; eff. Jan 1; impl. Jan. 4, 2010).

***CMS also instructed physicians to use modifier 50, not add-on codes, when facet joint injections are performed on both the left and right side of a level.*** An OIG audit report (<http://oig.hhs.gov/oei/reports/oei-05-07-00200.pdf>) found that a significant percentage of physicians incorrectly billed add-on codes, not modifier 50. Pub. 100-20, Trans. 526, CR 6518 (July 31; eff. /impl. Aug. 31, 2009).

***Trans. 20 to Part 2 of the Provider Reimbursement Manual updates the current cost report Form CMS-2552-96.*** The transmittal contains a list of significant revisions. Pub. 15-2-36, Trans. 20, July 2009.

***CMS is reminding home health providers that the date of service on claims for covered osteoporosis drugs must fall within the start and end dates of the home health episode.*** The transmittal also reviews the coverage criteria. Trans. 1773, CR 6512 (July 24, 2009; eff. Jan. 1; impl. Jan. 4, 2010).

***CMS has determined that Medicare will not cover computed tomography colonography (CTC) — also know as the virtual colonoscopy — for screening for colorectal cancer.*** Pub. 100-03, Trans. 105, CR 6578 (Aug. 7; eff. May 12; impl. Sept. 8, 2009).

***CMS has issued an exception to allow individuals in a rural area who are qualified as a registered dietitian and are certified as a diabetic educator by a CMS-approved organization to furnish training and to meet the multidisciplinary team requirement.*** The transmittal also recognizes the American Association of Diabetes Educators (AADE) as a national accreditation organization for purposes of accrediting entities to furnish outpatient diabetes self-management training. Pub. 100-02, Trans. 109, CR 6510 (Aug. 7; eff. March 30; impl. Sept. 8, 2009).

***On Aug. 19, as we went to press, HHS released its breach notification interim final rule to implement the new requirements imposed by the HITECH Act.*** The rule is posted at [www.federalregister.gov/OFRUUpload/OFRData/2009-20169\\_PI.pdf](http://www.federalregister.gov/OFRUUpload/OFRData/2009-20169_PI.pdf).

## Highlights of the FY 2010 Final IPPS Rule

***The FY 2010 Inpatient Prospective Payment System Final Rule offers the standard DRG changes, ICD-9-CM code changes, and wage index tables.*** There were limited revisions to the CC list, based solely on changes to the ICD-9-CM codes, and no changes in the surgical hierarchy.

One note of relief for hospitals is that CMS is not adjusting the FY 2010 payment rates to account for changes in payments due to coding and documentation. With the introduction of the MS-DRGs, CMS had said it would make such adjustments.

◆ ***DRGs Changes.*** The only major DRG revision was movement of procedure codes 80.05 and 80.06 to the higher paying DRGs 463, 464, and 465. These procedure codes represent hip or knee replacement procedures that become infected and require further inpatient services to remove the prosthesis. The titles of the codes also will change. The revised title for procedure code 80.05 is “Arthrotomy for removal of prosthesis without replacement, hip.” The revised title for procedure code 80.06 is “Arthrotomy for removal of prosthesis without replacement, knee.”

◆ The ICD-9-CM changes that take effect on Oct. 1, are listed in tables 6A through 6G. A code conversion table has been posted on the ICD-9-CM Web page, hosted by the National Center for Health Statistics — [www.cdc.gov/nchs/dataawh/ftpserve/ftp9/ftp9.htm](http://www.cdc.gov/nchs/dataawh/ftpserve/ftp9/ftp9.htm). This Web page also will post the FY 2010 official guidelines when they are available

◆ ***Changes to the Medicare Code Editor (MCE)***

— ***New edit.*** To address three new coverage decisions, CMS will establish a new edit, Wrong surgeries. It also will require hospital to report one of the relevant E-codes.

There is one revised E-code title and two new E-codes to identify cases in which incorrect surgeries have occurred. The revised E-code title for E876.5 is “Performance of wrong operation (procedure) on correct patient.”

The two new E-codes are as follows:

–E876.6, Performance of operation (procedure) on patient not scheduled for surgery

–E876.7, Performance of correct operation (procedure) on wrong side/body part

Regardless of whether these E-codes are in the principal or secondary diagnosis position, they will trigger the “Wrong Surgery” edit. Any claim with this edit will be denied.

If claims indicate that a wrong surgery was performed and no E-code is present, or if present, the code is reported in the wrong field, the RACs may review the claim and subsequently deny it. If a pattern of abuse is detected, the provider will be referred to the OIG for additional investigation.

— ***Males Only and Females Only.*** The following codes were inadvertently omitted from the Males Only and Females Only edits and will be added to the MCE as of Oct. 1, 2009:

Diagnosis Allowed for Males Only

- 603.0, Encysted hydrocele
- 603.1, Infected hydrocele
- 603.8, Other specified types of hydrocele
- 603.9, Hydrocele, unspecified

Procedures Allowed for Females Only

- 75.37, Amnioinfusion
- 75.38, Fetal pulse oximetry

— ***Manifestation Code as Principal Diagnosis Edit.*** The following codes are now acceptable principal diagnosis codes and are removed from the edit:

- 365.41, Glaucoma associated with chamber angle anomalies
- 365.42, Glaucoma associated with anomalies of iris
- 365.43, Glaucoma associated with other anterior segment anomalies

— ***Invalid Diagnosis or Procedure Code*** adds code 00.01 to the table of *valid* codes.

— ***Unacceptable Principal Diagnosis.*** CMS has finalized its proposal to remove the subcategory 209 codes (Neuroendocrine Tumors) from the edit. These codes were added to the ICD-9-CM for FY 2008, but because of a note to the cat-

egory, payers thought that none of the 209 codes was acceptable as a principal diagnosis. CMS deemed this interpretation to be incorrect. The removal of the codes from the edit is intended to prevent future misinterpretation.

◆ *Revised Cost Report.* In the rule, CMS discusses revisions to the Medicare Cost Report, a draft of which is now available for review at [www.cms.hhs.gov/PaperworkReductionActof1995](http://www.cms.hhs.gov/PaperworkReductionActof1995). The revised cost report will be used for periods beginning on or after Feb. 1, 2010. Among the changes, CMS will implement its decision to split the current cost center for “Medical Supplies Charged to Patients” into two lines: “Medical Supplies Charged to Patients” and “Implantable Devices Charged to Patients.” While the revised cost report CMS-2552-10 will not be fully available until February 2010, providers may use the two separate cost centers for supplies and implantable medical devices for cost reporting periods beginning on or after May 1, 2009. CMS has provided line 55.30 to report implantable devices charged to patients on the current form and line 69 on the proposed cost report.

◆ *Critical Access Hospitals (CAH).* The rule promulgates four policy changes affecting critical access hospitals:

— To comply with section 148 of MIPPA, CMS revised §413.70 of the regulations to allow CAHs to bill for outpatient diagnostic laboratory tests for a patient who is not physically present in the CAH at the time the lab specimen is collected as long as one of two conditions are met: the patient receives outpatient services at the CAH on the same day as the specimen is collected or an employee of the CAH collects the specimen. Note that it also has issued Trans. 1782, CR 6395 (July 30, 2009) to implement this provision of MIPPA.

— As finalized, facilities that only furnish clinical diagnostic laboratory services to CAHs must obtain provider-based status by Oct. 1, 2010, to receive payment based on reasonable cost. Without such a designation, the facility will be paid under the clinical laboratory fee schedule.

— Method II facilities will be paid at 100% of reasonable costs, not 101% of reasonable costs.

— For CAHs that find themselves reclassified as urban from rural because of changes to the Metropolitan Statistical Areas, CMS will allow a

two-year window for CAHs to seek a rural reclassification.

◆ *EMTALA.* CMS is revising §489.24(a)(2), which addresses the applicability of sanctions for an inappropriate transfer during a national emergency. The amendment states that a waiver of EMTALA sanctions only applies if the transfer arises out of the circumstances of the emergency. Sanctions waived for an inappropriate transfer or for the relocation or redirection of an individual to receive a medical screening examination at an alternate location are only in effect if the hospital to which the waiver applies does not discriminate on the basis of the source of an individual’s payment or ability to pay. Finally CMS proposes to clarify that the HHS secretary has the authority to apply the waiver of EMTALA sanctions to one or more hospitals in a portion of an emergency area or a portion of an emergency period and is not required to apply it to an entire area.

◆ *HACs.* With regard to hospital-acquired conditions (HACs), CMS did not add any new conditions but did add codes 813.46 and 813.47, Torus fracture of the ulna and radius and ulna, respectively, to the HAC category “Falls and Trauma.”

◆ *Quality Measures.* There are four additions to the quality reporting measures. These are

— SCIP Infection (INF) 9 Urinary Catheter Removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2)

— SCIP INF 10 Surgery Patients with Perioperative Temperature Management

— Participation in a Systematic Clinical Database Registry: Nursing Sensitive Care

— Participation in a Systematic Clinical Database Registry: Stroke Care

CMS also has established a new reconsideration process for hospitals that do not receive the full market basket update because they failed to meet the quality measures validation requirements. For FY 2010, these facilities may submit paper records each quarter to the CMS contractor along with the reconsideration form.

◆ *Chart Validation.* To address the many questions CMS has received regarding the process for chart validation by the Clinical Data Abstraction Center (CDAC), the agency is adopting a time line so that hospitals will know when they must

submit the records to validate the quality reporting. The CDAC will request paper medical records via certified mail, and the hospital will have 45 days from the date of the request, as documented on the request letter, to submit the records to the CDAC. If the hospital does not comply within 30 days, the CDAC will send a second certified letter to the hospital, reminding the hospital that it must return paper copies of the requested medical records within 45 calendar days following the date of the initial CDAC medical record request. If the hospital still does not comply, then the CDAC will assign a “zero” score to each data element in each missing record.

CMS also will change the validation process beginning in 2012. CMS will randomly select 800 hospitals each year and validate 12 medical records a quarter from each hospital (compared with the current 5).

◆ *New Technology.* CMS approved one item for New Medical Services and Technology add-on — Spiration IBV Valve system, which is used to treat persistent air leaks following three types of lung surgery. It did not approve Lipsan Coronary Imaging System because the agency concluded that it did not represent a substantial clinical improvement over existing technologies.

◆ *Financial Figures.* The market basket increase for IPPS acute care hospitals is 2.1%; the outlier threshold is \$23,140.

◆ *DSH calculation.* The final rule revises the disproportionate share hospital adjustment policies including what is and is not included in the Medicare DSH calculation patient days. As proposed, CMS will exclude all observation patient days from the disproportionate patient percentage of the Medicare disproportionate share hospital (DSH) calculation. For the same reasons, it also will eliminate from bed counting

observation bed days for patients who are subsequently admitted as inpatients. This change applies to both the DSH payment adjustment and the indirect medical education payment adjustment. This proposal would be effective for cost reporting periods beginning on or after Oct. 1, 2009.

**Long-Term Care Hospital PPS.** The IPPS final rule also includes the changes to the Long-Term Care Hospital PPS for rate year (RY) 2010, which begins on Oct. 1. The market basket increase for LTCHs is 2.5%, but is reduced by .5% to account for changes in documentation and coding that occurred in 2007. There is no documentation and coding adjustment for RY 2010. The outlier threshold is decreasing to \$18,245 from \$22,960. The DRG changes parallel those of the IPPS rule.

The final rule is published in the Aug. 27, 2009 *Federal Register* and is effective for Oct. 1, 2009 for IPPS and LTCH hospitals. The rule, and accompanying data table also is posted at [www.cms.hhs.gov/AcuteInpatientPPS/10FR/list.asp#TopOfPage](http://www.cms.hhs.gov/AcuteInpatientPPS/10FR/list.asp#TopOfPage).

***In addition to the final IPPS rule, CMS released the final FY 2010 rules*** for inpatient rehabilitation facilities (74 Fed. Reg. 39762 (Aug. 7, 2009)) and for skilled nursing facilities (74 Fed. Reg. 40288 (Aug. 11, 2009)). Both rules take effect Oct. 1, 2009. The IRF rule contains important changes to coverage requirements, which will be effective for discharges on or after Jan. 1, 2010. For a summary of the new requirements, see the fact sheet, “CMS Adopts Inpatient Rehabilitation Facility Coverage Requirements,” dated July 31 and posted at [www.cms.hhs.gov/apps/media/fact\\_sheets.asp](http://www.cms.hhs.gov/apps/media/fact_sheets.asp).

CMS also released the proposed rule for home health for 2010, that when final would take effect on Jan. 1, 2010 (74 Fed. Reg. 39436 (Aug. 6, 2009)).

## Returning Improper Payments

As a follow-up to last month's Current Developments' article titled "New Legal Exposure When You Fail to Repay Overpayments," the expansion of the Federal False Claims Act (FCA) increases providers' legal exposure in the retention of overpayments. Thus, it is important for providers participating in federal programs (e.g. Medicare) to understand their repayment options to the government.

The Centers for Medicare & Medicaid Services (CMS) have two options to return overpayments: (1) to submit a corrected claim to their fiscal intermediary (FI), carrier, or Medicare Audit Contractor (MAC); or, (2) to submit a voluntary refund to CMS. Each option has specific criteria and a number of requirements.

### Submitting a Corrected Claim

CMS offers two choices when submitting a corrected claim. Providers may request to reopen a claim determination and decision or to submit an adjusted claim.

### Reopening a Claim Determination and Decision

Reopening is defined as a "remedial action taken to change a final determination or decision that results in an overpayment or underpayment, even though the payment was correct based on the evidence record." This process allows providers to correct clerical errors, such as minor errors and omissions, without having to undergo a formal appeals process. CMS defines clerical errors as human or mechanical errors in form and/or content. This may include the following:

- ◆ Missing data items (e.g. provider number or date of service)
- ◆ Mathematical or computational mistakes
- ◆ Inverted procedure or diagnostic codes
- ◆ Inaccurate data entries
- ◆ Misapplication of CMS' fee schedule
- ◆ Technical errors (e.g. computer error)
- ◆ Incorrect data items
- ◆ Denials of claims as duplicate which the provider believes were incorrectly identified.

Reopening a claim determination and decision cannot always be requested. For example, a reopening is not permitted for the failure to bill a certain item or service. Also, providers may not request a reopening to correct third-party payer errors. Rather, these corrections may undergo CMS' claims adjustment process, which is explained below.

There are a number of criteria and requirements providers must comply with when requesting the reopening of a determination and decision. If a provider identifies an improper payment due to clerical errors, providers can request the CMS contractor to reopen a claim under the following time frames:

- ◆ Within one year from the date of the initial determination or redetermination for any reason
- ◆ Within four years from the date of the initial determination or redetermination for good cause
- ◆ At any time if the initial determination was not in favor of the provider; however, only if there was a clerical error that has been corrected.

Requests to reopen a claim must be by telephone or in writing. However, issues pertaining to liability, medical necessity denials and reductions, or analysis of documents, such as operative reports and clinical summaries may not be requested via telephone. Such requests must be provided in writing. If the provider elects to call the CMS contractor, the following information must be provided:

- ◆ Name of the provider, physician, or supplier of the item or service and their identification number (e.g. NPI) or National Supplier Clearinghouse number;
- ◆ Beneficiary's first initial and last name;
- ◆ Medicare Health Insurance Claim Number (HICN);
- ◆ Dates of service
- ◆ Item(s) or service(s) that require the correction;
- ◆ Reason for the request; and
- ◆ Proof to support correction (if necessary).

<b>Table 1: Time Limitation for Submitting Adjusted Claims</b>												
The timely filing date for all months except Oct., Nov., and Dec. is Dec. 31 of the service year plus 1 year. For the last calendar quarter, the timely file date is Dec. 31 of the service year plus 2 years. The number of months to file, based on the date of service, is shown below.												
Date of Service in:	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
Months to file*	23	22	21	20	19	18	17	16	15	26	25	24
* Months to file equals the number of full months plus the remainder of the service month.												

It is important to note that the final decision to reopen a claim is made by the CMS contractor. Thus, a contractor may determine that the issue requiring a reopening of a claim is too complex to be handled over the phone and may instruct the provider to submit their request in writing.

### Submitting an Adjusted Claim

The most common method to change or correct claims under Medicare Part A is through the claims adjustment process. Traditionally, providers file an adjustment on bill type XX7 (Provider debit) or XX8 (Provider cancel). To file an adjustment for bill type XX8, the adjustment can only recoup or cancel a prior payment, i.e., a credit, correct a provider identification number, or to correct the HICN. In the event, the claim is cancelled to resolve an incorrect provider identification number or HICN, the provider is required to submit a new bill.

CMS Form 1450 (CMS-1450) is used to request a claim adjustment. Providers may submit CMS-1450 to correct the following:

- ◆ Number of inpatient days (this includes changes in the length of stay or different allocation of covered or non-covered days)
- ◆ Blood deductible
- ◆ Inpatient case deductible greater than \$1
- ◆ Servicing provider
- ◆ Discharge status code in a prospective payment system (PPS) hospital
- ◆ Diagnosis or procedure codes that affect the assignment of a MS-DRG
- ◆ Outlier payment amount

When a request for a claim adjustment is submitted, providers are also required to report a

reason code on the CMS-1450 form. For bill type XX7, the following reason codes can be used:

D0 (change to service dates)

- ◆ D1 (change in charges)
- ◆ D2 (change in revenue codes or Healthcare Common Procedure Coding System)
- ◆ D3 (second or subsequent interim inpatient PPS bill)
- ◆ D4 (change in GROUPER input (this only applies to inpatient))
- ◆ D7 (change to make Medicare the secondary payer)
- ◆ D8 (change to make Medicare the primary payer)
- ◆ D9 (any other changes)
- ◆ E0 changes in patient status

For bill type XX8, the permitted reason codes are as follows:

- ◆ D5 (cancel-only to correct a HICN or provider identification number)
- ◆ D6 (cancel-only to repay a duplicate payment or the Office of Inspector General (OIG) overpayment)

Medicare providers should be aware when reporting reason code D4 (change in GROUPER input), D8 (change to make Medicare the primary payer); or D9 (any other changes), CMS contractors are required investigate the adjustment requests. Furthermore, CMS contractors are monitoring the use of reason code D9. If a provider is reporting this reason code frequently, CMS contractors are required to notify OIG to further investigate potential abuse.

Similar to reopening a determination or decision, there are time limitations when filing for an adjustment. Table 1 summarizes the adjustment time limits.

### Submitting a Voluntary Refund

When an overpayment is identified and the cause of the error does not meet the requirements to submit a corrected claim; providers should promptly submit an unsolicited voluntary refund to CMS. To submit a voluntary refund, providers must obtain an overpayment refund form from their respective FI, carrier, or MAC, which usually is posted on the contractor's Web page. The overpayment refund form will require the following information for each claim included in the voluntary refund:

- ◆ Patient name
- ◆ HICN
- ◆ Medicare claim number
- ◆ Claim amount refunded
- ◆ Reason for claim adjustment

CMS notes that a voluntary refund "in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue an appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims." Thus, providers are encouraged to submit information regarding corrective actions that have been implemented to remediate the cause of the overpayment.

### Conclusion

Overall, the expansion of the FCA illustrates the government's continued efforts to identify fraud

and abuse in federal programs. Therefore, it is imperative for providers to fully understand how to correct improper payments. The following flowchart provides a summary of CMS' repayment options.

If questions or concerns of CMS' repayment process arise, providers are strongly encouraged to contact their local carrier, FI, or MAC.

### Official Resources

CMS, Claims Processing Manual, CMS 100-04, Ch. 1, sec. 130, Adjustments and Late Charges.

CMS, Claims Processing Manual, CMS 100-04, Ch. 3, sec. 50, Adjustment Bills.

CMS, Claims Processing Manual, CMS 100-04, Ch. 34, Reopening and Revision of Claim Determinations and Decisions.

CMS, Medicare Financial Management Manual, CMS 100-06, Ch. 5, sec. 410, Unsolicited Voluntary Refunds.

"MMA – Section 937 – Correction of Minor Errors and Omissions Without Appeals." MLN Matters Number: SE0420.

"MMA – Reopenings and Revisions of Claim Determinations and Decisions." MLN Matters Number: MM4147.

"Unsolicited/Voluntary Refunds." MLN Matters Article Number: MM3274.

"Unsolicited Voluntary Refunds." TrailBlazer Health Enterprises Job Aids Publication. Oct. 2008.