

## **WPS Medicare Part A - Quarterly CERT Error Findings Report**

### **~ INDIANA~**

This report provides details of Comprehensive Error Rate Testing (CERT) errors assessed April 2014 through June 2014 for Indiana providers. The findings below are reported based on the type of error assessed by the CERT Contractor (e.g., insufficient documentation, incorrect coding, etc.).

#### **Medically Unnecessary Service or Treatment – 48% of total errors**

Reasons for Errors:

- Disagree with inpatient admission as being reasonable and necessary. Beneficiary had history of chronic renal insufficiency and presented to office with elevated potassium of 6.8. She had a recent history of diarrhea possibly related to C -diff. There was an associated metabolic acidosis which plus her ACE inhibitor use was a contributing cause of the hyperkalemia. She was monitored and treated with a prompt response to therapy. This was not new and was rapidly responsive to treatment. There was no intensive therapy to justify inpatient admission. Observation while the treatments were given would have been appropriate.
- Inpatient admission not reasonable & necessary: in ER for LE cellulitis; stable; no fever; WBC 10.7K. All could have been provided as outpatient services.
- Inpatient admission not reasonable & necessary: procedure without complication (Laparoscopic cholecystectomy without C.D.E. without CC/MCC). All could have been provided as outpatient services.
- Inpatient admission not reasonable & necessary: procedure without complication (Cardiac defibrillator implant without cardiac catheterization without MCC). All could have been provided as outpatient services.
- Inpatient admission not reasonable and necessary: stable; no reason cannot treat DVT as outpatient. Procedure reasonable: need to treat atrial arrhythmias, and thus need for pacer.
- Disagree with inpatient admission and invasive procedure (implantation of dual chamber ICD. Beneficiary has history of dementia and atrial fibrillation who presented after witnessed fall/syncope. There was a period of loss of consciousness so he was admitted to observation. He had a history of CAD S/P MI and PCI in past. Given his history he had echo and EPS done which showed EF of 30-35% and severe aortic stenosis with non-sustained ventricular tachycardia. Thus the procedure of placing an AICD was justified. However per NCD 20.4 and due to chronic atrial fib, only a single chamber AICD could be justified. Thus the dual chamber device was not warranted.

- Inpatient admission not reasonable and necessary. Beneficiary had dilated cardiomyopathy with EF of 30-35%. There was chronic permanent atrial fibrillation as well as chronic kidney disease. On 6/28 a dual chamber pacemaker was changed to a single chamber ICD. The RV lead was dislodged the night after surgery and she developed a hematoma. This was evacuated and the RV lead was repositioned. These are known and expected problems post ICD placement and do not require an inpatient admission. The facility is not on the ICD registry so it is unclear how many of these procedures are done there. Medically the procedure was justified but not the inpatient admission.
- Inpatient admission not reasonable and necessary: in ER with mild diverticulitis; no fever or leukocytosis; stable. All could have been provided as outpatient services.

### **DRG Wrong Diagnosis Code – 18% of total errors**

#### Reasons for Errors:

- Disagree with facility coded DRG of 458. Remove code 280.0, (chronic blood loss anemia) and replace with 285.1, (acute hemorrhagic anemia). Medical record documentation by the physician indicates the beneficiary had anemia secondary to blood loss and dehydration. Patient received PRBC for the anemia during the inpatient encounter. Also add code 996.49, (other mechanical complication of other internal orthopedic device). Per the signed operative report, the patient had flat back syndrome with "pseudoarthritis of L1-2, status post instrumented fusion from L1-L5".
- Disagree with facility coded DRG 872. Revise DRG to 690 with diagnosis 599.0(Urinary Tract Infection, Site Not Specified) re-sequenced as principal diagnosis. Diagnoses codes 038.9 (Unspecified Septicemia) and 995.91(Sepsis) are removed from the coding sequence. Per ED physician progress notes and admit orders, beneficiary had urosepsis. There is no documentation of sepsis in the submitted claim. Code 599.0 is a more appropriate principal diagnosis for the term urosepsis. Additional coding change supported in the documentation and guidelines that do not affect the new DRG 690: Add diagnosis 041.49 (E. Coli NOS).
- Disagree with facility coded DRG 253. Revise DRG to 252 with diagnosis code 262 (severe protein-calorie malnutrition) added to the coding sequence. Per discharge summary and progress notes of 03/25 beneficiary had severe protein calorie malnutrition, megace was added. Patient was severely deconditioned, calorie count ordered with gradual improvement at time of discharge.
- Disagree with facility coded DRG 458 with the principal dx code as idiopathic scoliosis. Per ICD-9-CM Official coding guidelines and available medical record documentation, the more appropriate principal dx is 722.52, (degenerative scoliosis) with the DRG changing to 460. Per the Pre-surgical assessment, operative report and Physician signed progress notes, the physician states "DDD spinal stenosis, sp decompression" and degenerative spinal stenosis. Additional coding changes supported in the documentation and guidelines that do not affect the DRG: Add procedure code 77.79 (excision of bone for graft) per operative report. Add diagnosis code V85.42 for body mass index over 45.

### **Insufficient Documentation - 13% of total errors**

#### Reasons for Errors:

- Missing MD signature and date on original orders. Submitted same orders with signature and date upon second request. This is not acceptable.
- Procedure 03.09 (Other exploration and decompression of spinal canal) and thus inpatient admission were not reasonable and necessary. There was little information about prior conservative care and no pre-op imaging was included.
- Disagree with the procedure of left total hip arthroplasty and thus admission as being reasonable and necessary. The beneficiary had a history of bilateral hip problems and had right hip replacement in November 2010. An office visit from June 2012 shows some hip pain but patient elected to wait. Next visit documented was June 2013 with "no complaints." She had no conservative treatments apparently over the course of the year but due to increased pain wanted to proceed with hip replacement. Without conservative treatment documentation, cannot approve surgical intervention. Thus, the procedure and the admission were not justified.

### **Invasive Procedure Not Medically Necessary – 9% of total errors**

#### Reasons for Errors:

- Disagree with facility coded DRG 243. Revise to DRG 281. Delete procedure codes 37.72/37.83 (insertion of leads into atrium and ventricle)/(insertion of dual chamber pacemaker). Procedure not reasonable and or necessary. Does not meet NCD or internal review guidelines for dual chamber pacemaker with: no mention or consideration of a single chamber pacemaker in the record, and no documented rationale for insertion of a dual chamber pacemaker instead of a single chamber pacemaker. The documentation does not support insertion of dual chamber pacemaker and A/V leads were reasonable and necessary.
- Disagree with facility coded DRG 243. Revise DRG to 309 with procedure codes 37.83 (initial insertion of dual chamber) and 37.72 (initial insertion of leads) removed from the coding sequence. Procedures 37.83 and 37.72 are not reasonable and necessary. Does not meet NCD or internal review guidelines for dual chamber pacemaker with: no mention or consideration of a single chamber pacemaker in the record, and no documented rationale for insertion of a dual chamber pacemaker instead of a single chamber pacemaker. Meets NCD and internal review guidelines for single chamber pacemaker with: complete heart block; 2nd degree AV block-Mobitz 1 and 2 with widened QRS. Symptomatic with syncope/presyncope and falls.

### **DRG Wrong Procedure Code – 4% of total errors**

#### Reasons for Errors:

- Disagree with facility coded DRG 245. Revise to 259 by replacing procedure code 37.98 (replacement defibrillator/pulse generator) with 37.85 (replacement of pacemaker device). Per AHA Coding Clinic May-June 1987 p.8, references pacemaker battery as "pulse generators". Per device report of medical record, reference is to a pacemaker generator not ICD.

## **Wrong discharge status code – 4% of total errors**

Reasons for Errors:

- Disagree with discharge disposition 01-Home as coded by the facility. The discharge disposition should be 06-Home with home health.

## **Other Errors – 4% of total errors**

Reasons for Errors:

- Disagree with inpatient admission for date of service, 08/31-09/01. There was no MD order for inpatient admission found on the medical record. ER physician notes “Will admit for observation”. ER Physician bed request for inpatient bed ordered 08/31 at 15:49. However, attending physician ordered Admit to Observation on 08/31 at 19:21.

**Based on CERT error findings for this quarter, below are educational resources that can assist your facility in avoiding these issues.**

### **CMS Resources**

- **Determining Medical Necessity and Appropriateness of Admission** - CMS IOM, PUB 100-08, Chapter 6, Section 6.5.2.a
- **Acute Inpatient PPS web page** - <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/>
- **Cardiac Pacemakers (NCD)** – CMS IOM, PUB 100-03, Chapter 1, section 20.8
- **Provider Signature Requirements** - CMS Internet-Only Manual(IOM), PUB 100-08, Chapter 3, Section 3.3.2.4
- **Requirements for Ordering and Following Orders for Diagnostic Tests**– IOM, PUB 100-02, Chapter 15, section 80.6.1

### **WPS Medicare Web Page Resources**

- CERT Identified Errors
- Medical Review
- On Demand Training
- Provider Specialties/Services



## **WPS Medicare Part B - Quarterly CERT Error Findings Report**

### **~ INDIANA ~**

This report provides details of Comprehensive Error Rate Testing (CERT) errors assessed April 2014 through June 2014 for Indiana providers. The findings below are reported based on the type of error assessed by the CERT Contractor (e.g., insufficient documentation, incorrect coding, etc.).

#### **Insufficient Documentation - 80% of total errors**

##### Reasons for Errors:

- Missing the physician order or clinical documentation of intent of ordering the billed Phenobarbital, quantitation of drug times 3 units, methadone, drug confirmation times 3 units, and column chromatography/mass spectrometry (CPT 80184, 80299, 83840, 80102, 82544). Missing signed and dated clinical documentation to support medical necessity for the billed labs. Also missing Phenobarbital, quantitation of drug times 3 units, methadone, drug confirmation times 3 units, and column chromatography/mass spectrometry lab results. Requested additional documentation from the listed ordering and billing provider and received no response.
- Billed lab test drug confirmation (1), benzodiazepines (1), urinalysis; qualitative or semi-quantitative, except immunoassays (1), chromatography, quantitative, column (EG, GAS LIQUID OR HPLC) (1), column chromatography/mass spectrometry, ; qualitative, single stationary and mobile phase (1), column chromatography/mass spectrometry; quantitative, single stationary and mobile phase (1) and drug screen, qualitative; multiple drug classes by high complexity test method (CPT 80102, 80154, 81005, 82491, 82541, 82542, G0431). Missing treating physician clinical records that support the need/reason/medical necessity for lab testing. Submitted physician order and lab results and multiple group therapy notes.
- Billed drug confirmation, each procedure, and urinalysis; qualitative or semi-quantitative, except immunoassays, methadone (80102, 81005, 83840, G0431). Missing the physician order or clinical documentation of intent to for ordering the tests and missing clinical documentation to support medical necessity of tests. Missing clinical documentation that supports medical necessity in a beneficiary who is "compliant with her medication" and "has no evidence of diversion or aberrant behavior" per office progress notes. This is the 4th time this drug screen was done in a compliant beneficiary in last nine months. Requested additional documentation from the ordering provider and received no response.
- Missing the ordering provider signed and dated clinical documentation to support medical necessity for the billed labs (CPT 82550, 80061, 84443, 85025, 83036, 80053). Submitted documentation included E-requisition and lab reports. Requested additional documentation from the ordering provider and received no response.
- Missing the physician order or clinical documentation of intent of ordering the billed lipid panel (CPT 80061). Submitted documentation includes results and a co-signed Lab requisition.

- Billed column chromatography/mass spectrometry, creatinine; other source, desipramine, doxepin, imipramine, and meprobamate (CPT 82570, 80160, 80166, 80174, 82542, 83805). Missing signed and dated clinical documentation to support medical necessity for the billed labs and physician order/ intent of ordering the tests. Received laboratory reports and unsigned visit note.
- Billed for travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated trip charge (P9604). Missing documentation of the mileage traveled. Documentation submitted includes an unsigned requisition form, and lab test results. Also received a travel requisition form showing 217 miles per patient which is not completely filled out by lab staff.
- Billed radiologic examination, chest, 2 views, frontal and lateral (CPT 71020). Missing the physician order or clinical documentation of intent of ordering the x-ray and clinical documentation to support medical necessity. Received chest x-ray report only. Requested additional documentation from the billing provider and received duplicate documentation.
- Billed manual therapy, therapeutic exercises, and therapy activities (CPT 97110-GO, 97140-GO, 97530-59-GO). Missing: 1) Treating physician's signed and dated certification of the Plan of Care; 2) Attestation statement from the therapist who performed OT on billed date; Submitted documentation included illegible signed treatment flow sheet and unsigned daily notes. Requested additional documentation from the billing provider and received signature log from the ordering provider, order missing long term goals to be consider a POC, and occupational initial evaluation with signature from the therapist only. The plan of care must contain, at minimum: Diagnoses; Long term treatment goals; and Type, amount, duration and frequency of therapy services. The plan must be reviewed, dated and signed by a physician/NPP to complete the certification requirements in 42CFR 410.61(e).
- Billed for chiropractic manipulative treatment (CMT); spinal, 3-4 regions (CPT 98941-AT) for date of service in August 2013. Missing: 1) clinical documentation supporting the date of the initial visit which shows symptoms causing patient to seek treatment; mechanism of trauma; quality and character of symptoms/problem; onset, duration, intensity, frequency, location and radiation of symptoms; aggravating or relieving factors; and prior interventions, treatments, medications, secondary complaints, and date of initial treatment; 2) the treatment plan showing recommended level of care; specific treatment goals; and objective measures to evaluate treatment effectiveness. Documentation submitted includes several NP notes and chiropractic progress notes dated May through August. Documentation submitted is insufficient.
- Billed chiropractic manipulation, CPT 98941-AT. Missing: 1) signed and dated initial evaluation with P.A.R.T Exam; 2) Signed and dated initial and subsequent treatment plans related to billed chiropractic services, and 3) All subsequent treatment notes prior to billed DOS. Submitted documentation included visit note dated billed date only. Without a treatment plan and documentation of areas of subluxation there is insufficient documentation submitted to support the billed service.
- Billed CPT 96523, irrigation of implanted venous access device for drug delivery systems. Missing: 1) Attestation statement of the person who performed billed service. Submitted documentation includes several office visit notes that support beneficiary is receiving Chemotherapy and unsigned flow sheet and attestation statement from the billing provider. Requested additional documentation from the billing provider and received beneficiary data form with insurance information, etc.

- Billed normal saline solution, per 250cc, 5 units of service (J7050). Missing physician's order for the normal saline as billed. Missing clinical documentation to support the infusion of normal saline was for other than to facilitate the infusion or injection or for incidental hydration. Submitted documentation included therapy note that saline was used to administer the pre-medications and chemotherapy that has been initialed by the nurse and signed by the treating physician.
- Billed for a hemodialysis procedure with single evaluation by a physician or other qualified health care professional (CPT 90935) and subsequent hospital care (CPT 99232). Missing the hospital progress note and the hemodialysis examination procedure note. Submitted includes multiple progress notes from other providers and a note from billing provider stating they billed wrong hospital, but with the correct charges, and submitted 2 days of hospital notes.
- Billed CPT 90791. Missing licensed clinical social worker's documentation to support psychiatric diagnostic evaluation. Submission includes statement that a thorough search of the files failed to reveal any record of this patient, discharge instructions and ED progress note.
- Billed anesthesia service (00810-QZ). Missing: 1) Billing provider signed and dated pre-anesthesia evaluation and 2) Billing provider signed and dated post-anesthesia evaluation. Submitted documentation includes colonoscopy report, anesthesia record and pre- and post-anesthesia orders. Requested additional documentation and received no response from the billing provider.
- Billed CPT 95117 - Professional Services for Allergen Immunotherapy for date of service in August 2013. Missing physician's updated treatment plan and dosage regimen applicable to the billed DOS and medical record/documentation such as Medical history and examination (including allergy testing) upon which the need for the treatment is based per LCD requirement. Also missing valid signature or attestation statement for the office visit note. Received from follow-up request includes authenticated OV note with nurse's note stating "currently on immunotherapy, frequency of immunotherapy 1 x 7 days, patient reached maintenance dose on July 10<sup>th</sup>. Insufficient documentation to support the billed service.
- Billed CPT 99211 (office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician, usually, the presenting problem(s) are minimal, typically, 5 minutes are spent performing or supervising these services). Missing a signature attestation statement for the unsigned office visit note. After follow-up request, received a duplicate office visit with signature added.
- Billed CPT 99232. Missing the billing provider signed and dated subsequent progress note. Submitted documentation includes several hospital inpatient notes. Requested additional documentation from the billing provider and received duplicate documentation.

### **Incorrect Coding - 16% of total errors**

#### Reasons for Errors:

- Billed CPT 99214 (Detailed history, detailed exam, and moderate MDM, requires 2/3 key components). Documentation supports down code to CPT 99213 with expanded problem focused history, comprehensive exam, and low complexity MDM. Submitted documentation includes a visit note indicating that the HPI reviewed per bullet points and to "see bullet points" for problem/plan but does not include these bullet points. No response from follow-up request. Coded E/M with the documentation received.

- Billed CPT 99220 requires 3 of 3 components (comprehensive history, comprehensive exam, and high complexity MDM). Documentation supports a down code from 99220 to 99218 as billed with detailed history (Limited ROS), comprehensive exam, and moderate MDM per 1995 E/M guidelines.
- Billed CPT 99223 - initial hospital care. Submitted note supports subsequent visit CPT 99233 with detailed history, comprehensive exam and moderate MDM, meeting 2 of 3 requirements of detailed history/detailed exam/high complexity MDM.
- Billed CPT 99233 requires 2 of 3 components (detailed history, detailed exam, and high complexity medical decision making). Documentation supports a down code from 99233 to 99232 as with Expanded Problem Focused History, Detailed Exam, and Moderate MDM per 1995 and 1997 E/M guidelines.
- Billed CPT 99233. Documentation supports a down code to 99232 with Expanded Problem Focused History, Expanded Problem Focused Exam, and moderate MDM per 1995 and 1997 E/M guidelines.
- Billed CPT 99233. Documentation supports a down code to 99232 with Problem Focused History (Limited HPI and No ROS), Expanded Problem Focused Exam per 1995 E/M guidelines, and Moderate MDM per 1995 E/M guidelines.
- Billed CPT 99285 requires 3 of 3 components (comprehensive history, comprehensive exam, and high complexity MDM). Documentation supports a down code from 99285 to 99284 with detailed history, comprehensive exam, and moderate MDM per 1995 E/M guidelines.
- Billed 99306 - Initial Nursing Facility Care requiring 3/3 Components; Comprehensive History and Exam and High complexity MDM. Documentation supports a down code to 99304 also requiring 3/3 Components; Detailed/Comprehensive History & Exam and Straightforward/Low MDM. Documentation is of Detailed History and Exam and Moderate MDM.

### **Medically Unnecessary Service or Treatment – 2% of total errors**

Reasons for Errors:

- Billed laboratory test is not medically necessary for lack of the verification of the treating physician's documentation to support medical necessity; therefore the venipuncture (CPT 36415) is not reasonable and necessary.

### **Other Errors – 2% of total errors**

Reasons for Errors:

- Billed CPT G0206 (Diagnostic mammography, producing direct digital image, unilateral, all views) with the ordering physician's NPI as the rendering provider as well. Submitted includes a letter from the billing provider stating in part that the claim was submitted in error with the ordering physician's NPI being identified as the rendering physician instead of the rendering radiologist's NPI and the claim has been submitted for correction. Of note, the claim was cancelled and resubmitted after CERT selection, and the correct performing radiologist's NPI was paid.



Based on CERT error findings for this quarter, below are educational resources that can assist in avoiding these issues in your practice.

### CMS Resources

- **Provider Signature Requirements** - CMS Internet-Only Manual(IOM), Publication 100-08, Chapter 3, Section 3.3.2.4
- **Requirements for Ordering and Following Orders for Diagnostic Tests**– IOM, PUB 100-02, Chapter 15, section 80.6.1
- **Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services** – IOM, PUB 100-02, Chapter 15, section 220.1
- **Identifying the Certifying Physician** - IOM, PUB 100-04, Chapter 5, section 10.3.F
- **Payment for Anesthesiology Services** – IOM, PUB 100-04, Chapter12, section 50
- **Selection of Level of Evaluation and Management Service** - IOM , PUB 100-04, Chapter 12, section 30.6.1

### WPS Medicare Resources

#### **Local Coverage Determinations (LCDs) for:**

- Allergy Testing and Allergy Immunotherapy
- Chiropractic Services
- Qualitative Drug Testing

#### **Additional WPS Medicare web page resources:**

- CERT Articles
- CERT Error Analysis
- Evaluation & Management Services (under Resources, Provider Specialties/Services)





## Medicare Part B - Current Updates July 2014

### Disclaimer

Every reasonable effort has been made to ensure the accuracy of this information. However, the provider has the ultimate responsibility for compliance with Medicare rules and regulations. WPS Medicare bears no liability for the results or consequences of the misuse of this information. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

### ICD-10 Compliance Date is October 1, 2015

Providers are required to continue to use ICD-9-CM through September 30, 2015. As additional information becomes available from CMS, we will publish that information in the weekly eNews. Sign up for WPS Medicare eNews at:  
<http://visitor.r20.constantcontact.com/manage/optin/ea?v=001B5adRIY4IqajYzHtZeaOuQ%3D%3D>

### Sign up for Medicare Learning Network

CMS national provider educational products, named The Medicare Learning Network® (MLN), share up-to-date educational information and accompany the release of new or revised Medicare program policies. Available educational tools include National Educational Articles, Brochures, Fact Sheets, Web-Based Training Courses, Videos and Podcasts.

For more details, please visit:

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html>

### Comprehensive Error Rate Testing (CERT) Program

CMS uses the CERT program to measure and improve the quality and accuracy of Medicare claims submission, processing, and payment. WPS Medicare uses the error rate information to ensure education will address and prevent the most common billing errors and claim denials.

CMS Comprehensive Error Rate Testing (CERT) Program web page  
<http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/index.html>

Iowa, Kansas, Missouri, and Nebraska

<http://www.wpsmedicare.com/j5macpartb/departments/cert/>

Indiana and Michigan

<http://www.wpsmedicare.com/j8macpartb/departments/cert/>

## **Internet-based Provider Enrollment, Chain and Ownership System (PECOS)**

Submit your Medicare Enrollment Application using Internet-based PECOS, the fastest, easiest way to enroll in the Medicare program or update your Medicare program enrollment record.

Get easy access to Internet-based PECOS by scanning the Quick Response (QR) code with your smartphone or visit:  
<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html>



The CMS 14 page publication (ICN 903767), titled "*The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations*" helps you use internet-based PECOS. You can download it here:  
[http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll\\_PECOS\\_ProviderSup\\_FactSheet\\_ICN903767.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf)

CMS published a 12 page (ICN 903764), titled "*The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners*" to help you use internet-based PECOS. You can download it here:  
[http://www.cms.gov/outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll\\_Pecos\\_PhysNonPhys\\_FactSheet\\_ICN903764.pdf](http://www.cms.gov/outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_Pecos_PhysNonPhys_FactSheet_ICN903764.pdf)

## **Revalidation of Medicare Provider Enrollment Information**

The Affordable Care Act requires providers and suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria.

This requirement applies to providers and suppliers enrolled in Medicare prior to March 25, 2011. Providers and suppliers who submitted their Medicare enrollment on or after March 25, 2011, are not impacted.



Wait to submit revalidation until after your Medicare Administrative Contractor asks you to do so. Revalidation notices will be sent out on or before March 2015.

Get easy access to the revalidation process by scanning the Quick Response (QR) code with your smartphone or visit: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads//SE1126.pdf>

## **CMS Medicare Billing Certificate Program**

After completing the CMS certificate program, learners will have knowledge about Medicare, master provider type billing specifics, and receive a Medicare billing certificate. Program completion includes: required web-based training courses, readings, and post-assessment scoring of 75% or higher. To participate in either the Part A and/or Part B program, or browse the entire list of CMS prepared web-based training courses, refer to the Related Links posted on the CMS Web-Based Training (WBT) web page, located at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html>

## **Customer Satisfaction Survey**

WPS Medicare strives to continue to improve our website to meet our providers' needs. We use the ForeSee Customer Satisfaction Survey as a primary means to gather your feedback and input and gauge your satisfaction with our website. Please take time to complete the Website Satisfaction Survey that pops up when visiting the WPS Medicare website.

## Medicare Quarterly Provider Compliance Newsletter

The Medicare Learning Network<sup>®</sup> (MLN) Products Provider Compliance page contains educational products informing Medicare Fee-For-Service (FFS) providers about how to avoid common billing errors and other improper activities when dealing with the Medicare Program. Since 1996, CMS has implemented several initiatives to prevent improper payments before a claim is processed and to identify and recoup improper payments after the claim is processed. The overall goal of CMS' claim review programs is to reduce payment error by identifying and addressing billing errors concerning coverage and coding made by providers.

To learn more, visit the CMS Provider Compliance page:

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html>

### eNews

WPS Medicare publishes our eNews Listserv three times a week. Monday's eNews contains the most current and vital information Medicare providers need to know including policy updates, current Medicare information, and changes as they happen. Wednesday second eNews contains educational opportunities and Thursday's the third eNews is a publication of a CMS Listserv. To sign up, visit the WPS Medicare website and select "eNews" in the upper right corner. We encourage everyone at provider offices to subscribe, as there are no restrictions on how many individuals can subscribe.



Get easy access to the sign-up website by scanning the Quick Response (QR) code above with your smartphone or visit: <http://corp-ws.wpsic.com/apps/commercial/unauth/medicareListservUserWelcomeLoadAction.do>

### CMS Secure Net Access Portal (C-SNAP) Part B Appeals Status

Check the status of your Part B Appeals with C-SNAP. All you need is the beneficiary's name, date of service or the Internal Control Number (ICN). Status is available within 10 days after request submission. Once completed, the Decision Date and the Decision are available.

For C-SNAP Technical Support assistance, please reference the C-SNAP On Demand trainings listed below. The training may provide you with the answer to your question. Also, review our new feature "Help Center."

Iowa, Kansas, Missouri, and Nebraska

[http://www.wpsmedicare.com/j5macpartb/training/on\\_demand/csnap-od.shtml](http://www.wpsmedicare.com/j5macpartb/training/on_demand/csnap-od.shtml)

Indiana and Michigan

[http://www.wpsmedicare.com/j8macpartb/training/on\\_demand/csnap-od.shtml](http://www.wpsmedicare.com/j8macpartb/training/on_demand/csnap-od.shtml)

If you have questions that cannot be resolved after reviewing the C-SNAP On Demand Training, please call Medicare Customer Service at

Iowa, Kansas, Missouri, and Nebraska  
(866) 518-3285

Indiana and Michigan  
(866) 234-7331

Get easy access to C-SNAP by scanning the Quick Response (QR) code above with your smartphone or visiting: <http://medicareinfo.com>

## **WPS Medicare Resources Web Page**

WPS Medicare offers a wide range of resources to assist providers. We regularly develop and improve our online resources to decrease providers' costs and time spent contacting WPS Medicare. Easy Access to the following information can be found under the Resources Tab: Acronyms Lookup, CMS/External Links, Modifiers, New Providers and Provider Specialties/Services, Tips for First Time Visitors and Website Updates. Information is available 24 hours a day, 7 days a week, at a time most suitable to providers' schedules.

Visit the WPS Medicare Resource Web Page:

Iowa, Kansas, Missouri, and Nebraska

<http://www.wpsmedicare.com/j5macpartb/resources/>

Indiana and Michigan

<http://www.wpsmedicare.com/j8macpartb/resources/>

## **Medicare Remit Easy Print (MREP)**



MREP enables providers and suppliers to view and print 835 files, saves time and money, generates several useful reports, makes remittances easy to navigate and view.

Get easy Access to MREP by scanning the Quick Response (QR) code above with your smartphone or visiting the WPS Medicare website below.

Iowa, Kansas, Missouri, and Nebraska

[http://www.wpsmedicare.com/j5macpartb/departments/edi\\_/mrep.shtml](http://www.wpsmedicare.com/j5macpartb/departments/edi_/mrep.shtml)

For assistance, please call (866) 518-3285 and follow the prompts for EDI assistance.

Indiana and Michigan

[http://www.wpsmedicare.com/j8macpartb/departments/edi\\_/mrep.shtml](http://www.wpsmedicare.com/j8macpartb/departments/edi_/mrep.shtml)

For assistance, please call (866) 234-7331 and follow the prompts for EDI assistance.

## **Medicare Incentive Programs**

Incentive payments are available to eligible professionals who meet the eligibility and reporting requirements for each program. In 2014, eligible professionals may choose to participate in the following payment incentive programs.

1. Physician Quality Reporting System – Medicare eligible professionals who satisfactory report data on quality measures for covered professional services furnished to Medicare beneficiaries.

Find more information on the Physician Quality Reporting System program on the CMS website: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>

2. Electronic Health Records (EHR) – Medicare eligible professionals, hospitals, and critical access hospitals for the “meaningful use” of certified EHR technology. Medicare eligible professionals may not earn incentives under the eRX and Electronic Health Records incentive programs at the same time.

Find more information on the EHR Incentive Program on the CMS website:  
<http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html>

### **CMS National Physician Payment Transparency Program: Open Payments Training Module for Providers**

CMS has produced a training module called "Are You Ready for the National Physician Payment Transparency Program?" Accessible via Medscape (<http://www.medscape.org/viewarticle/780900?src=cmsaca>) physicians can receive a maximum of 1.00 AMA PRA Category 1 Credit by participating in the activity and receiving a minimum score of 70% on the post-test. Through the activity, participants will learn more about OPEN PAYMENTS, the steps involved in collecting and reporting physician data, key dates for implementation, and actions they can take to verify their information in advance of website publication. Please note that this training is valid for credit through 3/26/14.

The module features Dr. Peter Budetti, Deputy Administrator and Director of the Center for Program Integrity and Dr. Shantanu Agrawal, Medical Director of the Center for Program Integrity and Director of the Data Sharing and Partnership Group.

Medscape accounts are free and users do not have to be health care professionals to register. Registration is on the landing page of <http://www.medscape.com>

### **CMS offers Free Mobile Applications (apps) to track payments under Open Payments**

In July 2012, the Centers for Medicare & Medicaid Services (CMS) introduced two free mobile applications (apps) to help physicians and health care industry users track their payments and other transfers of value that applicable manufacturers and applicable Group Purchasing Organizations (GPOs) will report under Open Payments. Created by a provision of the Affordable Care Act, Open Payments creates greater public transparency about the financial transactions among physicians, teaching hospitals, and drug and device manufacturers.

These apps are available to facilitate accurate reporting of required information, which will be available to the public and will be published annually on the Open Payments website. The mobile apps allow both industry and physician users to track payments and other transfers of value in real-time. One app is targeted specifically to physicians (*Open Payments Mobile for Physicians*) and the other one is for industry, including applicable manufacturers and applicable GPOs (*Open Payments Mobile for Industry*).

The mobile applications can be downloaded and used easily and conveniently on a mobile device. Both apps are compatible with the iOS (Apple™) and Android platforms; they are available free through the iOS Apple™ Store and Google Play™ Store.

For more information on Open Payments and the mobile app, please see the program website at <http://go.cms.gov/openpayments>

For more information regarding the enhancements made to the mobile apps based upon user feedback, please use the MLN Matters article on the topic. The article can be found online at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1402.pdf>.



## Medicare Part A - Additional Information

### Websites You Need to Know

WPS Medicare <http://www.wpsmedicare.com>

CMS <http://www.cms.gov>

### Let Your Voice Shape WPS Medicare's Website and Education!

There are several opportunities to provide feedback to WPS Medicare

- ❖ ForeSee survey
- ❖ Educational event surveys

WPS Medicare values your opinion. Please take the opportunity to complete a survey whenever you see a link.

### WPS Medicare eNews!

The WPS Medicare eNews is now offered through Constant Contact. Constant Contact offers improved features such as quick, easy registration and subscription management, HTML eNews presented in an attractive and easy-to-read format, a linkable table of contents and immediate communication of eNews to subscribers. You can contact today's presenter or go to <http://www.wpsmedicare.com> and click on eNews

### Open Payments Mobile Applications

CMS has developed two mobile applications (apps) to help physicians and health care industry users track their payments and other transfers of value that manufacturers and Group Purchasing Organizations (GPOs) may need for successful Open Payments reporting. One app is targeted specifically to physicians (Open Payments Mobile for Physicians) and the other one is for industry, including manufacturers and GPOs (Open Payments Mobile for Industry). Both apps are compatible with the iOS (Apple™) and Android platforms; they are available for download free through the iOS Apple™ Store and Google Play™ Store.

For more information on Open Payments and the mobile app, please see the program website at: <http://go.cms.gov/openpayments>

### ICD-10

The October 1, 2014, ICD-10 compliance date is fast approaching. By now, you should be employing identified preparation strategies. For detailed timelines and checklists for activities that all providers need to carry out to prepare for ICD-10, visit the CMS ICD-10 web page at: <http://www.cms.gov/Medicare/Coding/ICD10/index.html>

There is an On-line Implementation Guide, designed especially for small and medium practices, large provider practices, small hospitals and payers. These guides are available at:  
<https://implementicd10.noblis.org/>

To help WPS Medicare determine the readiness of our provider community for implementation of the ICD-10 codes, please complete a brief survey at:  
<http://survey.constantcontact.com/survey/a07e8twefakhqqm79v/start>

The survey is also posted on the ICD-10 page of the WPS Medicare website and can also be accessed on the ICD-10 page of the WPS Medicare website.

- ❖ Iowa, Kansas, Missouri and Nebraska  
<http://www.wpsmedicare.com/j5macparta/claims/icd-10/>
  
- ❖ Indiana and Michigan  
<http://www.wpsmedicare.com/j8macparta/claims/icd-10/>

### **Provider Contact Center**

WPS Medicare’s Provider Contact Center (PCC) is the first point of contact for providers who have additional questions.

<b>MAC Region</b>	<b>Contact Number</b>
J5 & J5 National MAC A	(866) 518-3285
J8 MAC A	(866) 234-7331

### **CMS Secure Net Access Portal (C-SNAP)**

WPS Medicare, in partnership with CMS, offers providers a FREE self-service portal as your comprehensive, secured website to be used as your primary Medicare information source for patient eligibility, claim status information and duplicate remittance notices. C-SNAP is available to you 24 hours a day 7 days a week. For more information on C-SNAP go to:

- ❖ J5 MAC and J5 National Part A  
<http://www.wpsmedicare.com/j5macparta/claims/claims-tools/csnap/index.shtml>
  
- ❖ J8 MAC Part A  
<http://www.wpsmedicare.com/j8macparta/claims/claims-tools/csnap/index.shtml>

### **Comprehensive Error Rate Testing (CERT) Program**

CMS uses the CERT program to measure and improve the quality and accuracy of Medicare claims submission, processing and payment. WPS Medicare uses the error rate information to ensure that our education will address and prevent the most common billing errors and claim denials. For more information on the CERT program go to:



- ❖ J5 MAC and J5 National Part A  
<http://www.wpsmedicare.com/j5macparta/departments/cert/index.shtml>
- ❖ J8 MAC Part A  
<http://www.wpsmedicare.com/j8macparta/departments/cert/index.shtml>

## WPS Medicare Interactive Voice Response Unit (IVR)

The Interactive Voice Response (IVR) offers easy access to Medicare information 24 hours a day. Simply call toll-free to obtain Medicare claims information, patient eligibility and much more!

### What is Available on the IVR?

Eligibility, Claim Status, Checks

Remittance Advice and Overlapping Claim Information

Region	Contact Number
J5 & J5 National MAC A	(866) 590-6702
J8 MAC A	(877) 567-7201

## HIPAA Eligibility Transaction System (HETS)

In the future, CMS plans to discontinue access to the Common Working File (CWF) queries through the Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE). Medicare providers and their agents that currently access the CWF queries through the FISS screens will need to modify their business processes to use HETS to access Medicare beneficiary eligibility information.

HETS allows Medicare providers and their agents to submit and receive X12N 270/271 eligibility request and response files over a secure connection. Many Medicare providers and their agents are already receiving eligibility information from HETS. For more information about HETS and how to obtain access to the system, refer to the CMS HETS Help web page at:

<http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/HowtoGetConnectedHETS270271.html>

More information may also be found in the following MedLearn (MLN) Matters article:

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1249.pdf>

## Detection of Duplicate Claims

The claims processing systems contain edits which identify duplicate claims and suspected duplicate claims. All exact duplicate claims or claim lines are auto-denied or rejected (absent appropriate modifiers). Suspect duplicate claims and claim lines are suspended and reviewed by WPS Medicare to make a determination to pay or deny the claim or claim line.

Some claims that appear to be duplicates are actually claims or claim lines that contain an item or service, or multiple instances of an item or service, for which Medicare payment may be made. Correct coding rules applicable to all billers of health care claims encourage the appropriate use of condition codes or modifiers to identify claims that may appear to be duplicates, but are in fact not.

Patterns of duplicate claim submission will be analyzed to determine whether certain providers are responsible for duplicates, and if so, those facilities will be identified. Education will be provided to those providers to reduce the number of duplicates. Should these providers continue to submit duplicate claims, WPS Medicare will initiate program integrity action.

More information may also be found in the following MLN Matters article:  
<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8121.pdf>

### Remittance Advice (RA) Information

Are you still receiving paper RAs and/or paper checks? If so, **GO GREEN!**  
It's FREE! For information on Electronic Data Interchange (EDI) go to:  
[http://www.wpsic.com/edi/edi\\_contact.shtml](http://www.wpsic.com/edi/edi_contact.shtml)

To gain a better understanding of the RA and the resources available, providers can access the Remittance Advice Information Fact Sheet at:

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Remit-Advice-Overview-Fact-Sheet-ICN908325.pdf>

and the Remittance Advice Resources at:

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Remit-Advice-Resources-Fact-Sheet-ICN908329.pdf>

Need more information on your Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs)? Just look here:

<http://www.wpc-edi.com/reference>

In DDE – choose option 16 and then 68

### Fraud and Abuse Prevention

CMS has produced two fraud and abuse prevention training modules available on the Medscape website at <http://www.medscape.com>

- ❖ “Reducing Medicare and Medicaid Fraud and Abuse: Protecting Practices and Patients”
  - Provides health care professionals with actionable ideas for working with CMS and other agencies that investigate suspected fraud and abuse.
  - <http://www.medscape.org/viewarticle/764496>
- ❖ “How CMS Is Fighting Fraud: Major Program Integrity Initiatives”
  - Increases awareness amongst providers about strategies CMS has undertaken to detect and prevent fraud and abuse in the Medicare and Medicaid programs.
  - <http://www.medscape.org/viewarticle/764791>

Prepared by WPS Medicare (J8)  
07/15/14

## Indiana State Medical Association – Coalition Meeting July 18, 2014

### Resources

CMS Medicare Learning Network (MLN) Matters Number SE1419, “Medicare Signature Requirements - Educational Resources for Health Care Professionals”

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1419.pdf>

CMS MLN Matters Number SE1237, “Importance of Preparing/Maintaining Legible Medical Records”

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1237.pdf>

CMS Internet-Only Manual, Publication 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.5 – Amendments, Corrections and Delayed Entries in Medical Documentation

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf>

WPS Medicare Provider Enrollment Changes

<http://www.wpsmedicare.com/i8macpartb/news/current-news/2014-0630-provider-enrollmentchanges.shtml>

WPS Medicare Archived Message Box Articles for J8 MAC B Providers

<http://www.wpsmedicare.com/i8macpartb/archived-messages.shtml>

WPS Medicare Website Updates (Weekly Listing)

<http://www.wpsmedicare.com/i8macpartb/resources/website-updates/>

Signature requirements

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1419.pdf>

Amending medical records

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1237.pdf>

# Indiana State Medical Association (ISMA) Coalition Meeting

Presented by: WPS Medicare  
July 18, 2014



## IPPS Final Rule Changes



## General Rule

- Surgical procedures, diagnostic tests and other treatments (including inpatient only procedures), are generally appropriate for inpatient hospital admission and payment under Medicare Part A when:
  - The physician expects the beneficiary to require a stay that crosses at least two midnights and
  - Admits the beneficiary to the hospital based upon that expectation

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## Inpatient Admission

- “Admit” refers to the decision to provide inpatient care
- Based on
  - Expected length of stay due to
    - Medical history
    - Severity of illness
    - Current medical needs
    - Predictability of complications



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## Medical Necessity

- Physician expects beneficiary to require
  - Any clinical level of hospital care
  - Spanning 2 midnights or more
- AND
- Admits beneficiary based upon that expectation
  - Formal admission order & certification required for Part A payment

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## 2-Midnight Benchmark

- Begins when patient starts receiving hospital services
- Intent is to provide consistent application of Part A benefits
  - Time, not clinical level of hospital services, used as benchmark



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## Time Included in Benchmark

- Outpatient services
  - Observation
  - Emergency department
  - Operating room
- Excludes
  - Pre-hospital services (simple triage)
  - Ambulance
  - Delays in care



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## Transfers - Initial Hospital

- Follow usual 2 midnight benchmark
- Include only expected or actual time at initial facility
- Do not include any anticipated length of stay after transfer

## Transfers

- Receiving hospital
  - Include all pre-transfer time and care provided in the initial hospital
  - Beneficiaries who have already received two midnights of medically necessary hospital care in the initial hospital should be admitted by receiving hospital regardless of the expected length of stay in the receiving hospital
    - Request support documentation from initial provider

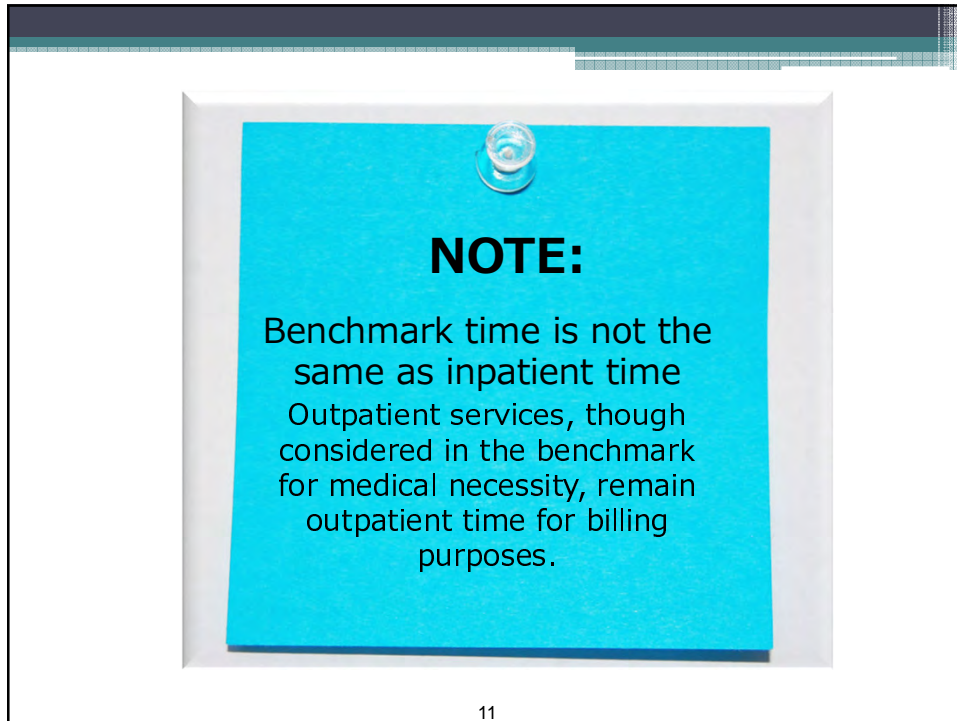
9

## Exceptions to the Benchmark

- No expectation of 2 midnight stay required
  - Order and certification still required
- Inpatient-only procedures
- Newly initiated mechanical ventilation
  - Does not include routine intubation of outpatient surgical patients

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## Admission Order

- Must be furnished by qualified licensed practitioner, knowledgeable about patient case
  - Includes non-physician practitioners
    - Admitting privileges
    - Licensed by the state to admit
    - Granted privileges by hospital

## Admission Order

- Must contain instructions to formally admit for inpatient
- Begins the inpatient stay
- If missing or invalid
  - Intent may establish inpatient stay
  - Bill outpatient



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## Knowledgeable About the Patient

- Hospitalist
- Admitting physician of record (“attending”)
- Beneficiary’s primary care practitioner
- Surgeon responsible for a major surgical procedure
- Emergency or clinic practitioner at beneficiary’s point of inpatient admission

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## Other Knowledgeable Provider

- “On call” physician
- Another provider actively treating patient at time of admission



**Does not include utilization review committee physician unless actively treating patient at time of admission**

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## Timing of Order

- At or before the time of inpatient admission
  - Can be written in advance but admission does not occur until formal admission to hospital
- Admission before inpatient order
  - Admission does not commence until order is documented

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## Retroactive Orders

- Medicare does not permit retroactive orders or the inference of orders
- Authentication of the order is required prior to discharge
  - May be performed and documented as part of the certification



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## Bridge Orders

- Written by a practitioner that does **not** have admitting privileges
- Also called
  - Status orders
  - Placement orders
  - Holding orders



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## Bridge Order

- Not a valid admission order
  - Unless cosigned by a practitioner that meets requirements
    - Prior to discharge
- **If new order is written by admitting physician (instead of cosigning the bridge order) admission date/time corresponds with new order**

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## Verbal Orders/Telephone Orders

- Written by a practitioner that does **not** have admitting or bridge order privileges
- Includes the identity the ordering physician or practitioner
- Authenticated by ordering physician or practitioner
  - Or another practitioner with admitting privileges
  - Prior to discharge or sooner if State requires

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## Physician Certification

- Required for Part A payment
- Contains rationale for admission
  - Supports 2 midnight expectation



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## Certification Timing

- Begins with admit order
- Completed, signed, dated and documented prior to discharge
- Exceptions:
  - Outlier cases
  - CAHs must certify no later than 1 day prior to the date on claim submission date



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## Authorization to Sign Certification

- **Physician responsible for case**
  - Another physician with knowledge of case
  - Admitting/attending or person on call
  - Surgeon
    - Responsible for surgical procedure
    - Surgeon on call
  - Dentist
  - Non-physician/non-dentist practitioner
    - Licensed by state
    - Admitting privileges

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## Discharge Summary Signature Clarification

- Are certification requirements met if the discharge summary is not signed prior to discharge?
  - Yes, CMS would consider the requirement for a certification signature prior to discharge met if:
    - Order for admission is properly authenticated
    - All the elements of the certification are provided in the medical record

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## Certification Format

- No specific forms or procedures
- Providers may adopt any method that permits verification
- May be entered and signed on forms, notes or records



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## Elements to Meet Certification

- Authenticated order
- Reason hospital inpatient services are required
- Estimated time
- Post hospital plan
- 96 hour requirement (CAH)

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## Shorter Than Expected Stays

- Unforeseen circumstances
  - Death, transfer, against medical advice (AMA), unexpected recovery
  - Clearly document in medical record
  - No penalty to provider



**Do not convert  
to an outpatient stay for  
billing purposes**

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## Probe and Educate



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## Includes dates of admission from October 1, 2013 - March 31, 2015



### Goals

Identify claims non-compliant with CMS-1599-F

Issue denials for improper claims

Educate providers about CMS-1599-F

### Excludes

Critical Access Hospital (CAH)

Inpatient Rehabilitation Facility (IRF)

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## Other Hospital Reviews

- Current reviews not affected
  - Coding
  - Procedure medical necessity
  - Admissions prior to 10/01/13
- May include review of CAH claims

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## Presumption

- Inpatient claims that span 2 midnights
  - Presumed to be medically necessary
- Not part of probe and educate
  - May edit for other hospital reviews
- Monitoring for systematic gaming or changes in billing practice

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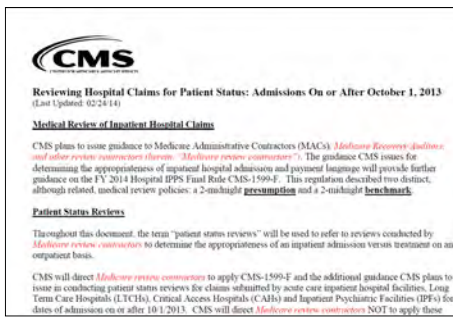
## Claim Selection Phase 1

- Reason code 58500
- **Dates of admission 10/1/13-3/31/14**
- Claims that span 0-1 midnights
  - 10 claims – most facilities
  - 25 claims – large facilities
- Additional claim requests
  - Replace excluded claims

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## Review Criteria

- MACs will assess compliance with
  - Admission order
  - Certification
  - 2 midnight benchmark



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## Reopening of Prior Decisions

- CMS request
- All denials made on or before January 30, 2014
  - Paid claims will not be reopened
- Ensure compliance with most recent clarifications
- 120 day timely filing for appeals waived
  - Appeals must be received by September 5, 2014

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## Phase 1 Reviews (58500)

- Ended in April 2014
- All final letters from WPS Medicare mailed as of May 28, 2014
  - To contact listed in PECOS



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## Provider Education

- Optional – at provider's request
- Submit request via email to address on letter received
  - Two week timeframe to request education
- Nurse Analyst will contact to arrange provider specific educational teleconference

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## Phase 2 Review

- Prepay
- Reason code 5CR85
- Begins the later of:
  - 45 days from date of final letter
  - 45 days after provider education teleconference
- Includes providers with
  - Moderate or high levels of concern
  - OR**
  - Providers with incomplete samples during phase 1

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## Review Criteria

- Last update 3/12/14
- MACs will assess compliance with
  - Admission order
  - Certification
  - 2 midnight benchmark

[CMS.gov > Home > Research, Statistics, Data and Systems > Medicare Fee-for-Service Compliance Programs > Medical Review and Education > Inpatient Hospital Reviews](#)

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## Review Results



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## Short Stay Procedures

- **Error**
  - Patient presented for short stay procedure and discharged the next day
    - Not on inpatient-only list
- **Prevention**
  - Procedures with typical expected length of stay of less than 2 midnights should be outpatient
    - May admit later for complication that lengthens stay

40

## Missing or Flawed Order

- **Error**
  - Physician order states “observation” but facility billed as an inpatient
- **Prevention**
  - Use specific language for inpatient orders
  - All care is assumed outpatient in the absence of an inpatient order
    - Or clear intent

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## Uncertain Course/Short Stay Medical Condition

- **Error**
  - Patient with complaints of dizziness
  - Physician notes state intention to monitor overnight but patient admitted and inpatient claim billed
- **Prevention**
  - When clinical course is uncertain, utilize outpatient observation
  - Keep as an outpatient until it is clear the patient requires two midnights of care

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## Attestation without Support

- **Error**
  - Checkbox stating “The beneficiary is expected to require 2 or more midnights of hospital care”
  - Physician notes state plan to discharge in a.m. if stable and patient discharged next day
- **Prevention**
  - Certification statements not required or adequate to support payment
  - Expectation must be supported by entire medical record

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## Thank You for Attending

- **DISCLAIMER:** *WPS Medicare has produced this material as an informational reference. Every reasonable effort has been made to ensure the accuracy of this information at the time of publication, however, WPS Medicare makes no guarantee that this information is error-free and bears no liability for the results or consequences of the misuse of this information. The provider alone is responsible for correct submission of claims. The official Medicare Program provisions are contained in the relevant laws, regulations and rulings and can be found on the CMS Website at [www.cms.gov](http://www.cms.gov).*

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