Physician’s Compliance Guide

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2013
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needs and condition and in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member.

Effective April 1, 2012, CMS announced a cap of $25 on reimbursement associated with copying medical records requested as the result of a RAC documentation request. The cap amount is a combination of the 12 cents per page photocopy charge and the cost of a first class stamp.

**Prepayment Review Demonstration**

On August 27, 2012, the Prepayment Review Demonstration took effect and gave permission to Medicare Recovery Audit Contractors (RACs) to review claims prior to issuing payment to ensure provider compliance with all Medicare payment policies and regulations. RACs will be conducting these reviews on claim types that have a historically high rate of payments issued in error. Initially, the reviews will target seven states with high populations of fraud and error prone providers: Florida, California, Michigan, Texas, New York, Louisiana, and Illinois as well as four states with higher than usual claims volumes for short inpatient hospital stays: Pennsylvania, Ohio, North Carolina, and Missouri. CMS believes this demonstration will help facilitate a reduction in the improper payment error rate by proactively reviewing claims to identify issues rather than trying to identify improper payments after they have already occurred.

At the time of printing, RACs were reviewing the following issues:

**Region A: Diversified Collection Services, Inc.**

<table>
<thead>
<tr>
<th>Audit Issue</th>
<th>State(s)</th>
<th>Description of Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add-On Codes Paid without a Paid Required Primary Procedure</td>
<td>CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT</td>
<td>Claims overpaid for add-on codes when the required primary procedure was not billed or was not paid for other reasons. Therefore, an issue may exist when these codes are billed and reimbursed under Medicare Part B in this manner.</td>
</tr>
<tr>
<td>Anesthesia Care and Packaged Evaluation Management Services</td>
<td>MA, ME, NH, NY, RI, VT</td>
<td>Identification of overpayments associated with evaluation and management services billed the day prior to or day of anesthesia services by an anesthesiologist. 1) E/M services (as specifically defined in the IOM) billed the day prior to or day of anesthesia services without modifiers 24, 25, or 57. 2) E/M services billed the same day as 01996 without modifiers 24, 25, or 57.</td>
</tr>
<tr>
<td>Bilateral In Nature Procedures</td>
<td>CT, DC, DE, MA, ME, MD, NH, NJ, NY, PA, RI, VT</td>
<td>Overpayment associated with payment for procedures that are bilateral in nature that exceed the price of a single unit of service.</td>
</tr>
<tr>
<td>Blood Transfusions</td>
<td>CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT</td>
<td>A potential vulnerability may exist if certain blood transfusion codes are billed for more than one (1) unit per date of service. Therefore, an issue may exist when these codes are billed and reimbursed under Medicare Part B in this manner.</td>
</tr>
<tr>
<td>Bronchoscopy Services</td>
<td>CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT</td>
<td>A potential vulnerability may exist if certain bronchoscopy services are billed for more than one (1) unit per date of service. Therefore, an issue may exist when these codes are billed and reimbursed under Medicare Part B in this manner.</td>
</tr>
<tr>
<td>Clinical Social Worker during Inpatient Hospital</td>
<td>CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT</td>
<td>CSW services rendered during an inpatient acute care or skilled nursing facility stay are not separately payable under Medicare Part B; instead they are included in the facility’s Prospective Payment System (PPS). CSW providers are expected to render services under arrangement with the facility. Therefore, an issue may exist when a patient received CSW services during an inpatient stay, which have been billed and reimbursed under Medicare Part B.</td>
</tr>
<tr>
<td>CT Scans, Head and Neck, Incorrect Billing</td>
<td>CT, NY</td>
<td>Potential incorrect billing of CT scans not supported by medical necessity (NGS LCD 28516 (A48015)).</td>
</tr>
<tr>
<td>CT Scans, Trunk and Extremities, Incorrect Billing</td>
<td>CT, NY</td>
<td>Potential incorrect billing of CT scans not supported by medical necessity (NGS LCD 28516 (A48015)).</td>
</tr>
</tbody>
</table>
Payment for Colonoscopy Services

Investigating Agency:
Office of Inspector General

Source Document:
2009 OIG Work Plan

Start Date:
FY 2009

Explanation of Investigation:
The OIG indicated they will be reviewing the appropriateness of Medicare payments to physicians for colonoscopy services.

Background:
The OIG is concerned that due to the different types of colonoscopies (i.e., diagnostic, surgical, and screening) providers may not be billing for these services appropriately. The agency also states that they are concerned that documentation in the medical record may not support the service being billed.

Investigative Findings:
Results from the Comprehensive Error Rate Testing (CERT) program have consistently found errors in the coding and payment of colonoscopy services over the past years. The November, 2007 CERT report indicates that upon review of 285 claims there was a 0.1 percent error rate that resulted in $895,402 in inappropriate payments.

The May 2008 CERT report indicates that there was once again a 0.1 percent error rate within the 259 claims reviewed, which resulted in a projected $643,913 in improper payments.

<table>
<thead>
<tr>
<th>Service Types Billed to Carriers (BETOS)</th>
<th>Paid Claims Error Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Error Rate</td>
</tr>
<tr>
<td></td>
<td>Number of Line Items</td>
</tr>
<tr>
<td></td>
<td>Projected Improper</td>
</tr>
<tr>
<td></td>
<td>Payments</td>
</tr>
<tr>
<td></td>
<td>Standard Error</td>
</tr>
<tr>
<td></td>
<td>95% Confidence Interval</td>
</tr>
<tr>
<td>Endoscopy-colonoscopy</td>
<td>0.1%</td>
</tr>
<tr>
<td></td>
<td>285</td>
</tr>
<tr>
<td></td>
<td>$895,402</td>
</tr>
<tr>
<td></td>
<td>0.1%</td>
</tr>
<tr>
<td></td>
<td>(0.1%) - 0.3%</td>
</tr>
</tbody>
</table>

Source: November 2007 Report, Comprehensive Error Rate Testing

Strategies for Risk Prevention:
There are a number of factors that affect the coding and billing of colonoscopy services.

Coverage:
Coverage guidelines for colonoscopies are dependent upon the type of service being rendered.

Diagnostic and Surgical Endoscopy:
A diagnostic endoscopy is a covered service if it is proven to be medically reasonable and necessary to the overall diagnosis and treatment of the patient's condition. Services are considered medically necessary when they meet one or more of the following requirements:

- Are proper and needed for the diagnosis or treatment of the patient's medical condition
- Are furnished for the diagnosis, direct care, and treatment of the patient's medical condition
- Meet the standards of good medical practice
- Are not mainly for the convenience of the patient, provider, or supplier

Screening Colonoscopy:
Medicare provides coverage of a screening colonoscopy for all beneficiaries regardless to age. A doctor of medicine or osteopathy must perform this screening.

- Beneficiaries at high risk for developing colorectal cancer: Medicare provides coverage of a screening colonoscopy once every two years for beneficiaries at high risk for colorectal cancer.
- Beneficiaries not at high risk for developing colorectal cancer: Medicare provides coverage of a screening colonoscopy once every 10 years but not within 47 months of a previous screening sigmoidoscopy.
Coding Guidelines

Surgical vs. Diagnostic Endoscopy
AMA guidelines indicate that a diagnostic endoscopy is an integral part of a surgical endoscopy and should not be billed separately. CCI instructions agree stating “surgical endoscopy includes diagnostic endoscopy. A diagnostic endoscopy HCPCS/CPT code should not be reported with a surgical endoscopy code.”

Multiple Endoscopies
When multiple endoscopic procedures are performed, providers should report the most comprehensive code describing the services according to both AMA and CCI guidelines. If multiple services are performed and not adequately described by a single HCPCS/CPT code, more than one code may be reported. Multiple procedure modifier 51 should be appended to the secondary HCPCS/CPT code. Only medically necessary services may be reported. Incidental examination of other areas should not be reported separately.

When more than one endoscopy is performed during the same operative session, report only the most extensive services.

Biopsies, Brushing and Washings
Brushings and washings are considered an integral part of a diagnostic endoscopy and therefore should not be reported separately.

When multiple biopsies are obtained, report the appropriate surgical endoscopy code only once, regardless of the number of specimens obtained.

It is appropriate, however, to report both a biopsy and an excision code when two separate sites are involved.

If a biopsy is performed on the same lesion that was removed, it is separately reportable only when the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the results of the pathologic examination. Modifier 58 should be appended to indicate that the biopsy and excision procedure were planned or staged procedures. If however, the results of the biopsy are not reported until after the removal, the biopsy should not be reported separately.

Control of Bleeding
Control of bleeding due to a surgical endoscopy, such as the biopsy or removal of lesions, is considered to be an integral part of the procedure and is not reported separately.

Removal of Lesion
The correct reporting of the removal of a lesion is determined by the method of excision. AMA guidelines indicate that when various techniques are used to remove multiple lesions it is appropriate to report the appropriate code for each method.

Incomplete or Failed Colonoscopy
An incomplete or failed colonoscopy occurs when the provider is unable to advance the scope past the splenic flexure.

AMA guidelines state that when this occurs the provider should report the colonoscopy service with code 45378 with modifier 53. The Medicare physician fee schedule database (MPFSDB) has specific values for code 45378-53. These values are the same as those for code 45330, sigmoidoscopy, as failure to extend beyond the splenic flexure means that a sigmoidoscopy rather than a colonoscopy has been performed. The provider should not report a sigmoidoscopy (CPT code 45330) since some of the MPFSDB indicators are different for codes 45378 and 45330.

Screening Colonoscopy
Correct coding assignment is dependent upon the patient’s level of risk. Levels of risk are defined above. For patients who are considered at a high level of risk, HCPCS Level II code G0105 should be reported.

G0105 Colorectal cancer screening: colonoscopy on individual at high risk

For patients who are not at a high level of risk, providers should report G0121.

G0121 Colorectal cancer screening: colonoscopy on individual not meeting criteria for high risk

Polypectomy Performed During Screening Endoscopy
There are also times when the provider, while performing a screening colonoscopy, finds an abnormality that is removed. CMS coding guidelines indicate:

“If during the course of such screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening colonoscopy but shall be made for the procedure classified as a colonoscopy with such biopsy or removal.”

The appropriate CPT code for the surgical endoscopy should be reported on the claim. Furthermore, the initial diagnosis should be the appropriate V code for the screening service since that is the primary reason why the encounter was performed. A second ICD-9-CM code indicating the finding should also be reported.

For example, if the patient undergoes a screening colonoscopy and a polyp is found and removed by snare, this would be reported as shown on the following page: