

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

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

## Documentation

### General Information

Below are some key points:

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

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

Although the terminology of these letters may vary, it is important to send all information that will support the claim. For non-laboratory services, this is the billing provider's responsibility, regardless if she or he has created it. For example, when seeking reimbursement for a diagnostic

test, the performing (billing) provider should not only submit the report but also the order and the referring provider's office notes that document the medical necessity for the study. If the information received fails to support the coverage or coding of the claim, in full or in part, the contractor must deny the claim, in full or in part (CMS Online Manual System, Pub. 100-8, Program Integrity Manual, Chapter 3, Section 3.4.1.2A).

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

### **Cloning of Medical Notes**

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

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

### **Evaluation and Management Coding**

#### **Procedure Code/Diagnosis Code Linking**

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

#### **Volume of Documentation vs. Medical Necessity**

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

#### **Shared Visits**

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

In the office/clinic setting:

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

In the hospital inpatient/outpatient/ER setting:

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

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

## **Scribing**

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

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

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

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

## **Provider Qualification**

## **Training and Expertise**

CMS Online Manual System, Pub. 100-8, Program Integrity Manual, Chapter 13, Section 5.1 (<http://www.cms.hhs.gov/manuals/downloads/pim83c13.pdf>) outlines that “reasonable and necessary” services are “ordered and/or furnished by qualified personnel.” Services will be considered medically reasonable and necessary only if performed by appropriately trained providers.

This training and expertise must have been acquired within the framework of an accredited residency and/or fellowship program in the applicable specialty/subspecialty or must reflect extensive continued medical education activities. If these skills have been acquired by way of continued medical education, the courses must be comprehensive, offered or sponsored or endorsed by an academic institution in the United States and/or by the applicable specialty/subspecialty society in the United States, and designated by the American Medical Association (AMA) as category I credit.

## **Drugs and Biological Products**

### **General**

In order to be covered under Medicare, use of a drug or biological must be safe and effective and otherwise reasonable and medically necessary. The medical reasonableness and necessity of drugs and biologicals are extensively discussed in the Medicare manuals.

First Coast Service Options, Inc. (FCSO) has published numerous local coverage determinations (LCDs) and educational articles about drugs and biologicals, specifically anti-cancer agents. Please refer to these publications for more detailed information. The training requirements listed under “Provider Qualification” apply.

### **Dosage and Frequency**

Drugs or biologicals approved for marketing by the FDA are considered safe and effective when used for indications specified on the labeling. The labeling lists the safe and effective, i.e., medically reasonable and necessary dosage and frequency. Therefore, doses and frequencies that exceed the accepted standard of recommended dosage and/or frequency, as described in the package insert, are considered not medically reasonable and necessary and, therefore, not reimbursable.

### **Route of Administration**

CMS Online Manual System, Pub. 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 50.4.1 addresses medical reasonableness and necessity based on the FDA approval and labeling: “Drugs or biologicals approved for marketing by the FDA are considered safe and effective for purposes of this requirement when used for indications specified on the labeling.” This statement extends to the mode of administration that is considered safe and effective, i.e., medically reasonable and necessary by Medicare’s criteria. Furthermore, the CMS Online Manual System, Pub. 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 50.2 K – Reasonable and Necessary, stipulates that “carriers and fiscal intermediaries will make the determination of reasonable and necessary with respect to the medical appropriateness of a drug to treat the patient’s condition. Contractors will continue to make the determination of whether the intravenous or injection form of a drug is appropriate as opposed to the oral form.”

Based on the above, for agents administered parenterally, the mode of administration (IV, IM, SQ) must be in keeping with the instructions in the package insert, as approved by the FDA. If a drug is available in both oral and injectable forms and both forms are equally effective, the oral preparation shall be used, unless there is a medical reason not to do so.

### **Wastage**

CMS Online Manual System, Pub 100-4, Medicare Claims Processing Manual, Chapter 17, Section 40, Discarded Drugs and Biologicals addresses wastage as: "CMS encourages physicians to schedule patients in such a way that they can use drugs most efficiently. However, if a physician must discard the remainder of a vial or other package after administering it to a Medicare patient, the program covers the amount of drug discarded along with the amount administered.

**Note:** The coverage of discarded drugs applies only to single use vials. Multi-use vials are not subject to payment for discarded amounts of drug."

Payment for wastage will only be made when single-use vials have to be utilized. No reimbursement will be made for wastage in the case of multi-use vials.

### **Place of Service and Patient Safety**

In situations when life threatening and other severe adverse reactions could be expected as a result of the administration of certain drugs or the performance of other services, the administration/performance of these services must take place in a facility equipped and staffed for cardiopulmonary resuscitation and where the patient can be closely monitored by qualified personnel for an appropriate period of time based on his or her health status. For specific services, FCSO may proscribe a place of service (POS) by way of an LCD or other publication.

### **Unit Dose and Decimal Point Errors**

The number of billable units may not be equal to the dose administered. For example, if a HCPCS code descriptor calls for 100 mg of a given agent, the number of units for 1000 mg administered would be 10 and not 1000. Similarly, if the descriptor reads 50 mg and 100 mg are administered, the correct number of units to bill is 2.

### **Diagnostic Tests**

#### **Medical Necessity and Documentation**

*Code of Federal Regulations (CFR)*, Title 42, part 410.32, specifies that all diagnostic tests must be ordered by a provider who is the treating provider for the patient and who will use the test results in the patient's care (in regards to the treating provider, there may be exceptions for the diagnostic radiologist in certain institutional inpatient or outpatient patient settings). For laboratory tests, additional documentation of medical necessity may be requested of the referring (treating) provider (CMS Online Manual System, Pub. 100-08, Chapter 3, Section 3.4.1.2).

Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary. Like with any service reimbursed by Medicare, to support medical necessity there must be documentation in the medical record as to why a certain modality was chosen/performed. This entire documentation - not just the test report or the finding/diagnosis on the order - must be available to Medicare upon request (please see also under "Responding to

Additional Documentation Request (ADR) Letters and Requests from the Comprehensive Error Rate Testing (CERT) Contractor” in this article).

### **Portable Diagnostic Equipment**

Medicare recognizes that the miniaturization of electronic devices is an on-going trend that may be associated with either improved or diminished test performance. Hand-carried diagnostic equipment ranges in complexity and capability from lightweight pocket-sized units completely contained within the examiner’s hand, to complex equipment systems where only a part, such as the ultrasonic probe itself, is hand-held. The appropriate assignment of a specific ultrasound CPT code is not solely determined by the weight, size, or portability of the equipment, but rather by the extent, quality, and documentation of the procedure. To be reimbursable by Medicare, a diagnostic ultrasound test must meet at least these minimum criteria (this is not an all inclusive list):

- It must be medically reasonable and necessary for the diagnosis or treatment of illness or injury.
- It should be done for the same purpose as a reasonable physician would order a standard ultrasound examination.
- It must be billed using the CPT code that accurately describes the service performed.
- The technical quality of the exam must be in keeping with accepted national standards and not require a follow-up ultrasound examination to confirm the results.
- The study must be performed and interpreted by qualified individuals.
- The medical necessity, images, findings, interpretation and report must be documented in the medical record.

### **Purchased Interpretations**

According to the CMS Online Manual System, Pub 100-4, Medicare Claims Processing Manual, Chapter 1, Section 30.2.9.1 “A person or entity that provides diagnostic tests may submit the claim, and (if assignment is accepted) receive the Part B payment, for diagnostic test interpretations which that person or entity purchases from an independent physician or medical group if:

- The tests are initiated by a physician or medical group, which is independent of the person or entity providing the tests and of the physician or medical group providing the interpretations;
- The physician or medical group providing the interpretations does not see the patient; and
- The purchaser (or employee, partner, or owner of the purchaser) performs the technical component of the test. The interpreting physician must be enrolled in the Medicare program. No formal reassignment is necessary.”

Furthermore, it is noted in the Final Rule of 2005 that “Arrangements involving reassignment must not violate any other applicable Medicare laws or regulations governing billing or claims submission, including, but not limited to, those regarding “incident to” services, payment for purchased diagnostic tests, and payment for purchased test interpretations.”

Consequently, a provider who initiates (orders) a test cannot purchase the interpretation and bill it to Medicare as professional component. For example, if a physician or a group perform testing on their patients with their own ultrasound equipment, and a radiologist, who is not a member of the practice, reads the tests, the group can bill only for the technical component (modifier TC). The radiologist must bill Medicare separately for the interpretation (professional component, modifier 26).

Source: Eugene J. Winter, M.D., Medical Director for First Coast Service Options, Inc.