Billing & Reimbursement Tips For 2012
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Important to Remember

The information provided in this presentation is for informational purposes only. Information is provided for reference only and is not intended to provide billing, coding, reimbursement or legal advice.

Laws, regulations, and policies concerning reimbursement are complex and are updated frequently and should be verified by the user. Please consult your legal counsel or reimbursement specialist for any reimbursement or billing questions.

You are responsible for ensuring that you appropriately and correctly bill and code for any services for which you seek payment. Oplinc does not guarantee the timeliness or appropriateness of the information contained herein for your particular use.
Maintain Accurate Patient & Payer Information
Common Demographic Errors

PATIENTS
- Name
- Address
- Date of birth
- SSN or other policy identifier
- Employer information
- Guarantor information
- Insurance information

PAYERS
- Primary or Secondary coverage
- Address for claims
- Provider number
- EDI payer ID
- Establish policy for maintaining & updating patient/payer demographics
- Perform detailed patient specific coverage & benefit analysis
- Establish Financial Counseling program & process
- Track:
  - Accuracy of patient/payer demographics
  - Denials due to coverage issues
  - Denials due to no prior-authorization
  - Patient balances
Understand Your Managed Care Contracts
Payments

- Know what services should be paid
  - Do they follow AMA CPT billing/coding rules?
  - Are there services not payable in your office?
- Know your contracted allowable for each service
  - Load all allowable amounts in your billing program
  - Monitor payments that differ from the contracted allowable
  - Keep these up to date!
Contract Details

- Appeal rights and process
- Who determines medical necessity?
- Timely filing
- Late payments
- Process audits and reviews
  - Limitations on retrospective audits
- Site of service limitations
- Drug policies
Master Evaluation & Management Coding
### Northern California (NCAL) E/M Comparative Billing Reports: Peer Code Comparison

**Sorted by Procedure Code Within Specialty Code**

**Dates of Service: 7/1/2011 - 12/31/2011**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Specialty Description</th>
<th>Code</th>
<th>Carrier Services</th>
<th>NCAL Specialty % of Use</th>
<th>National Specialty % of Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>83</td>
<td>Hematology/Oncology</td>
<td>99212</td>
<td>4,131</td>
<td>3.08%</td>
<td></td>
</tr>
<tr>
<td>83</td>
<td>Hematology/Oncology</td>
<td>99213</td>
<td>38,915</td>
<td>29.02%</td>
<td>35.19%</td>
</tr>
<tr>
<td>83</td>
<td>Hematology/Oncology</td>
<td>99214</td>
<td>70,434</td>
<td>52.52%</td>
<td>50.07%</td>
</tr>
<tr>
<td>83</td>
<td>Hematology/Oncology</td>
<td>99215</td>
<td>20,633</td>
<td>15.38%</td>
<td>10.77%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>134,113</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Insufficient Documentation

- Billed CPT 99213-25
- Submitted documentation does not support beneficiary was seen for a "significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service".
- Submitted progress note states: "Patient is here for chemo. No new problems. Physical Evaluation: same as last visit."
<table>
<thead>
<tr>
<th>99211 Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Must Show a clinically relevant &amp; necessary exchange of information between provider and patient, and</td>
</tr>
<tr>
<td>• Demonstrate an influence on patient care (ex., medical decision making, patient education, etc.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>99211 Should Not be Used For</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Phone calls to patients</td>
</tr>
<tr>
<td>• Drawing of blood for laboratory analysis or when performing other diagnostic tests</td>
</tr>
<tr>
<td>• Administration of medications when an injection or infusion code is submitted separately</td>
</tr>
</tbody>
</table>
- Provide ongoing E/M coding workshops for providers
- Review Medicare guidance on 99211
- Review E/M Comparative Billing Reports
- Audit E/M documentation for:
  - Level of service properly coded
  - New patient visits
  - Patient specific information for that particular date of service
  - Proper use of modifier 25
Make Sure Documentation Includes Orders & Signatures
Documentation for Drugs

Medical necessity

- Diagnoses specific to drugs/services
- Signed physician order with drug name and dose

Support variation - if anything differs from the package insert:

- Dose
- Frequency
- Route of administration
- Length of administration
- Use of supportive care drugs i.e., antiemetics
Documenting Drug Administration

- Signed physician order for drug(s) administered, dosage, frequency and duration of treatment
- Route of administration
- Start/stop time for each fluid/drug
- Concurrent or sequential
- Date of service
- Signature of individual providing the service
Time Based Codes

- Document time for:
  - Infusion codes
  - Prolonged service codes 99354-99357
  - E/M visits for counseling and/or coordination of care
  - Care Plan Oversight
Signature Requirements

Services provided/ordered must be authenticated by the ordering provider

- **Must Be Legible**
- **Handwritten or Electronic**
## Unique Signature Situations

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>PERFORMED BY</th>
<th>SIGNATURE REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident To</td>
<td>Ancillary Staff</td>
<td>Must be signed by billing provider.</td>
</tr>
<tr>
<td></td>
<td>NPP (Non-physician provider)</td>
<td>May be signed by the NPP or the supervising physician.</td>
</tr>
<tr>
<td>Split/Shared Office/clinic setting</td>
<td>NPP and physician</td>
<td>Must be signed by billing provider.</td>
</tr>
<tr>
<td>Split/Shared hospital inpatient/outpatient/Emergency dept. setting</td>
<td>NPP and physician</td>
<td>Must be signed by billing provider.</td>
</tr>
<tr>
<td>Scribe</td>
<td>Ancillary staff</td>
<td>The scribes name must be listed in the medical record and identified as a scribe. The signature of the scribe is not required; however, the billing provider must sign.</td>
</tr>
</tbody>
</table>

[www.palmettogba.com](http://www.palmettogba.com)
- Review Medicare requirements on orders
  - Audit medical records for signed orders
  - Chemotherapy orders should include all drugs including supportive care drugs
- Review Medicare signature requirements
  - Audit medical records for legible signed records
- Review Medicare guidelines for missing or eligible signatures
  - Signature attestation
Identify Sanctioned Coding & Billing Guidelines
Medicare Sanctioned Coding Guidelines

- Written Medicare Policy including
  - National Coverage Determination (NCD)
  - Local Coverage Determination (LCD)
- Medicare article
- AMA CPT statement
- AMA CPT Assistant statement
- AHA Coding Clinic statement
Important Articles

- CPT® Assistant 3 Part Series on Drug Administration
  - Part 2: June 2007 Volume 17, Issue 6
  - Part 3: September 2007 Volume 17, Issue 9
- CPT Assistant Coding Clarification Hydration
  - June 2008, Volume 18, Issue 6
- AMA Article on Consultation Changes
The Medicare Learning Network® (MLN) Products Provider Compliance page contains educational products that inform Medicare Fee-For-Service (FFS) providers on how to avoid common billing errors and other improper activities when dealing with the Medicare Program. Since 1996, the Centers for Medicare & Medicaid Services (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.

The MLN products and MLN Matters® Articles on this page are designed to provide education on common billing errors and other improper activities identified through various claim review programs and help Medicare FFS providers avoid such errors. To download a list of related articles and products, including the "Medicare Quarterly Provider Compliance Newsletter," which highlights the top issues of that particular quarter, go to the "Downloads" section below. These lists are updated as new products and articles are developed and existing products and articles are revised.

If you would like to contact the MLN, please e-mail us at MLN@cms.hhs.gov.

Downloads
- Medicare Parts C and D Fraud, Waste, and Abuse Training [ZIP, 497KB]
- Medicare Fraud & Abuse, Fact Sheet (October 2011) [PDF, 459KB]
- Provider Compliance MLN Products [PDF, 183KB]
- Provider Compliance MLN Matters® Articles [PDF, 110KB]
- Archive of Medicare Quarterly Provider Compliance Newsletters [PDF, 123KB]
- MLN Catalog of Products [PDF, 8MB]
- How to Sign Up for MLN Educational Products Electronic Mailing List [PDF, 117KB]
- How To Sign Up For MLN Matters® [PDF, 154KB]
- CMS Electronic Mailing Lists: Keeping Medicare Fee-For-Service Providers Informed [PDF, 410KB]
National Correct Coding Initiative Edits

Important notice to all NCCI Users concerning the National Correct Coding Initiative Policy Manual for Medicare Services:

The annual updated version of the National Correct Coding Initiative Policy Manual for Medicare Services will be effective January 1, 2012 rather than October 1, 2011. This manual will be posted on the NCCI website on or around December 1, 2011.

As of April 1, 2012, a revision to Chapter 8 (CPT codes 60000-68989), Section C. Nervous System, Paragraph #15, Pages VIII-7-8 has been posted on the CMS’ NCCI web page.

Downloads

How to Use The National Correct Coding Initiative (NCCI) Tools [PDF, 5MB]
R1386CP [PDF, 167KB]
MM5824 [PDF, 71KB]
NCCI Policy Manual for Medicare Services - Effective January 1, 2012 [ZIP, 637KB]
Chapter 23 - Fee Schedule Administration and Coding Requirements [PDF, 1MB]
Modifier 59 Article: Proper Usage Regarding Distinct Procedural Service [PDF, 59KB]
N. Chemotherapy Administration

1. The CPT codes 96360, 96365, 96374, 96409, and 96413 describe “initial” service codes. For a patient encounter only one “initial” service code may be reported unless it is medically reasonable and necessary that the drug or substance administrations occur at separate intravenous access sites. To report two different “initial” service codes use NCCI-associated modifiers.

2. CPT codes 96360-96379, 96401-96425, and 96521-96523 are reportable by physicians for services performed in physicians’ offices. These drug administration services should not be reported by physicians for services provided in a facility setting such as a hospital outpatient department or emergency department. Drug administration services performed in an Ambulatory Surgical Center (ASC) related to a Medicare approved ASC payable procedure are not separately reportable by physicians. Hospital outpatient facilities may separately report drug administration services when appropriate. For purposes of this paragraph, the term “physician” refers to M.D.’s, D.O.’s, and other practitioners who bill Medicare claims processing contractors for services payable on the “Medicare Physician Fee Schedule”.

3. The drug and chemotherapy administration HCPCS/CPT codes 90760-90775 and 96401-96425 have been valued to include the work and practice expenses of CPT code 99211 (evaluation and management service, office or other outpatient visit, established patient, level I). Although CPT code 99211 is not reportable with chemotherapy and non-chemotherapy drug/substance

Revision Date (Medicare): 1/1/2012
XI-24
- Review coding books each year
- Subscribe to Medicare sanctioned coding resources
  - Monitor for changes in billing rules/guidance
- Monitor CMS Provider Compliance website
- Maintain file of coding/billing guidance from Medicare contractor & private payers
Verify Drugs are Correctly Billed
If after administering a dose/quantity of the drug or biological to a Medicare patient, a physician, hospital or other provider must discard the remainder of a single use vial or other single use package, the program provides payment for the amount of drug or biological administered and the amount discarded, **up to the total amount of the drug or biological as indicated on the vial or package label.**

Multi-use vials are not subject to payment for discarded amounts of drug or biological.

Intentional Overfill

CMS clarified that “overfill”, including overfill pooled from more than one container, should not be billed to Medicare:

“Payment for amounts of free product, or product in excess of the amount reflected on the FDA approved label, will not be made under Medicare.”

Coverage policy does not prohibit the use of overfill

Medicare Physician Fee Schedule Final Rule 2011
Do not use the JW modifier when the actual dose of the drug administered is less than the billing unit. For example:

The billing unit for a drug is equal to 10mg of the drug in a SDV. A 7mg dose is administered & 3mg of the remaining drug is discarded. The 7mg dose is billed using one billing unit that represents 10mg on a single line item.

The single line item of 1 unit is processed for payment of the total 10mg of drug administered and discarded.

Billing another unit on a separate line item with the JW modifier for the discarded 3mg of drug is not permitted because it would result in overpayment.

Therefore, when the billing unit is equal to or greater than the total actual dose and the amount discarded, the use of the JW modifier is not permitted.

Off-Label Cancer Chemotherapy Use

- For off-label use, submit HCPCS code J9999, even though the drug may have an assigned HCPCS code.
- Indicate 'off-label chemo drug - special consideration' in the electronic documentation field (Loop 2300, or 2400, NTE, 02). If you are permitted to submit paper claims, submit this information in Item 19 of the CMS-1500 claim form.
- The name of the drug, NDC number and dosage must also be submitted in these fields.

www.palmettogba.com  Updated 1/1/2012
Subsequent claims - same patient for off-label cancer chemotherapy

- Submit HCPCS code J9999
- Indicate 'off-label chemo drug - special consideration' in the electronic documentation field (Loop 2300, or 2400, NTE, 02). If you are permitted to submit paper claims, submit this information in Item 19 of the CMS-1500 claim form.
- The name of the drug, NDC number and dosage must also be submitted in these fields
- No additional documentation for off-label use is required once the initial claim for that patient has been paid.

www.palmettoga.com Updated 1/1/2012
- Audit for correct billing of drugs
  - Units billed
  - NDC # where included
  - Wasted drug
- Know your Medicare contractor’s rules for
  - Documenting wasted/discarded drug
- Track drug denials to identify potential trends/issues
Avoid Common Billing Errors for Drug Administration
1 Initial code per encounter – *with a few exceptions*

Initial code determined by primary reason for encounter

Hydration must be >30 minutes

Infusions of <16 minutes – billed as IV push

“Concurrent” infusions – must be in separate bags
Do not bill IV push for port flushes

Do not report venipuncture when blood draw is from port

Billing - Round infusion hours to the nearest 30 minutes

Leucovorin & Mesna – bill with non-chemo admin codes

Hydration administered “concurrently” not separately billable
- Provide staff involved in billing access to updated billing/coding resources
- Provide ongoing coding and billing compliance training – *include RNs if they are responsible for choosing billing codes*
- Perform audits routinely to identify billing/coding errors
- Track denials/incorrect payments due to coding errors
Follow “incident to” Rules
### “Incident To” Requirements

- The services are commonly furnished in a physician’s office
- The physician must have initially seen the patient
- There is direct personal supervision by the physician of auxiliary personnel
- The physician has an active part in the ongoing care of the patient
• Co-signature & credentials of the practitioner providing the service & the supervising physician in documentation.

• Indication of supervising physician’s involvement through:
  • Notation of supervising physician’s involvement within the text of the associated medical record entry. Or,
  • Documentation from other dates of service, other than those requested, establishing the link between the two providers.
- Review CMS guidance on “incident to” services including split/shared visits
- Identify private payer “incident to” rules
- Review practice policies for physician supervision for services requiring direct supervision
- Review medical records for documentation supporting “incident to” billing
Prepare for Audits/Reviews
PREPARING FOR AUDITS

1. Assign an Audit Coordinator who is detail oriented and has sufficient time to devote to audit activities.
2. Organize your audit team and assign responsibilities.
3. Identify your practice risk areas by evaluating patterns of current denials, issues identified internally through audit and compliance activities.

Review medical record documentation for:
- Proper diagnoses
- Medical necessity
- Orders
- Signatures
- Correct coding and use of modifiers

Develop tracking process:
- Track record requests, type of service audited, records submitted, date of response, whether there was an overpayment, date of recoupment, requests for redetermination and/or appeals, outcome of appeals.
## CERT 2010 Medicare Improper Payment Report

<table>
<thead>
<tr>
<th>Service</th>
<th>Projected Improper Payments</th>
<th>Error Rate</th>
<th>Insufficient Documentation</th>
<th>Medically Unnecessary Services</th>
<th>Incorrect Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits – new</td>
<td>$292,486,069</td>
<td>24.0%</td>
<td>30.5%</td>
<td>2.1%</td>
<td>64.5%</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>$251,015,056</td>
<td>19.8%</td>
<td>95.1%</td>
<td>4.6%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Office visits – established</td>
<td>$1,475,533,109</td>
<td>12.3%</td>
<td>54.4%</td>
<td>0.5%</td>
<td>42.8%</td>
</tr>
<tr>
<td>Other drugs</td>
<td>$436,214,485</td>
<td>8.4%</td>
<td>63.1%</td>
<td>30.9%</td>
<td>5.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Paid Claims Error Rate</th>
<th>Insufficient Documentation</th>
<th>Medically Unnecessary Services</th>
<th>Incorrect Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hematology/Oncology</td>
<td>12.9%</td>
<td>79.5%</td>
<td>6.5%</td>
<td>13.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Error Rate</th>
<th>Projected Improper Payments</th>
<th>Provider Compliance Error Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hematology/Oncology</td>
<td>12.9%</td>
<td>$460,343,064</td>
<td>19.2%</td>
</tr>
</tbody>
</table>
Medicare A/B RAC Contractor

Region D: HealthDataInsights
https://racinfo.healthdatainsights.com/
The Medicare Quarterly Compliance Newsletter

- Describes the issue, problems that may occur as a result of the issue;
- Steps CMS has taken to make providers aware of the issue;
- Recommendations on what providers need to do to avoid the problem;
- References other documents for more detailed information.
Document
Medical Necessity

10
Medical Necessity

“Services or items reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

Centers for Medicare and Medicaid Services
What Was Done or Not Done & Why?

Record what you did or did not do and why

Example: A chemo drug classified as low emetic risk, *Emesis that has been documented to occur in 10% to 30% of patients*, but under certain circumstances the use of an antiemetic is warranted. May be based on:

- Dose of drug
- Combinations of drugs
- Patient’s response to treatment
- Patient’s disease
Track denials for patterns:

- Incorrect ICD-9 codes
- Combined therapies
- Route of administration oral vs. IV
- Off-label use
THANK YOU!

Rise@Oplinc.com
Resources
Checklist: CERT E/M
Documentation Requests

This list is a reminder of what to include when responding to a request for E/M documentation. The documentation should include, but is not limited to:

- Name of beneficiary and date of service on all documentation
- Signed physician’s orders, if applicable
- Test results, if applicable
- Documentation based on counseling or coordination of care, to include:
  - Total time
  - Amount or percent of time involved in counseling or coordination of care
  - Description of the discussion
- Signed physician progress notes, if applicable, to include:
  - History
  - Physical exam
  - Decision making for the dates of services in question
- If consultation, include:
  - Copy of request for consultation
  - Written report of consultation findings
- If using electronic medical records/signatures include documentation validating the process

## Provider Options - RAC Overpayment Determination

<table>
<thead>
<tr>
<th></th>
<th>Discussion Period</th>
<th>Rebuttal</th>
<th>Redetermination</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Which option should I use?</strong></td>
<td>The discussion period offers the opportunity for the provider to provide additional information to the RAC to indicate why recoupment should not be initiated. It also offers the opportunity for the RAC to explain the rationale for the overpayment decision. After reviewing the additional documentation submitted the RAC could decide to reverse their decision. A letter will go to the provider detailing the outcome of the discussion period.</td>
<td>The rebuttal process allows the provider the opportunity to provide a statement and accompanying evidence indicating why the overpayment action will cause a financial hardship and should not take place. A rebuttal is not intended to review supporting medical documentation nor disagreement with the overpayment decision. A rebuttal should not duplicate the redetermination process. (See 42 CFR 405.374-375)</td>
<td>A redetermination is the first level of appeal. A provider may request a redetermination when they are dissatisfied with the overpayment decision. A redetermination must be submitted within 30 days to prevent offset on day 41.</td>
</tr>
<tr>
<td><strong>Who do I contact?</strong></td>
<td>Recovery Audit Contractor (RAC)</td>
<td>Claim Processing Contractor</td>
<td>Claim Processing Contractor</td>
</tr>
<tr>
<td><strong>Timeframe Begins</strong></td>
<td>Automated Review: Upon receipt of Demand Letter</td>
<td>Date of Demand Letter</td>
<td>Upon receipt of Demand Letter</td>
</tr>
<tr>
<td><strong>Timeframe Ends</strong></td>
<td>Day 40 (offset begins on day 41)</td>
<td>Day 15</td>
<td>Day 120</td>
</tr>
<tr>
<td><strong>Timeframe</strong></td>
<td>Day 1 - 40</td>
<td>Day 1-15</td>
<td>Must be submitted within 120 days of receipt of demand letter. To prevent offset on day 41 the Redetermination must be filed within 30 days.</td>
</tr>
</tbody>
</table>

The medical record should be complete and legible

- Documentation of each patient encounter should include:
  - Reason for encounter, relevant history, physical examination findings & prior diagnostic test results;
  - Assessment, clinical impression or diagnosis;
  - Plan for care; date and legible identity of the observer.
- If not documented, the rationale for ordering diagnostic & other ancillary services should be easily inferred.
- Past & present diagnoses should be accessible to the treating and/or consulting physician.
- Appropriate health risk factors should be identified.
- The patient's progress, response to & changes in treatment, and revision of diagnosis should be documented.
- The CPT and ICD-9 codes reported on the claim form or billing statement should be supported by the documentation in the medical record.

<table>
<thead>
<tr>
<th>AUDIT PREPARATION CHECKLIST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understand who may audit your claims;</td>
</tr>
<tr>
<td>Understand the billing/coding rules &amp; where to find official sources of billing/coding guidance;</td>
</tr>
<tr>
<td>Develop &amp; implement a billing compliance plan;</td>
</tr>
<tr>
<td>Establish communication lines for reporting compliance concerns;</td>
</tr>
<tr>
<td>Establish an audit readiness management program;</td>
</tr>
<tr>
<td>Form an audit response team;</td>
</tr>
<tr>
<td>AUDIT PREPARATION CHECKLIST</td>
</tr>
<tr>
<td>-----------------------------</td>
</tr>
<tr>
<td>Regularly review &amp; monitor audit issues;</td>
</tr>
<tr>
<td>Perform practice risk analysis &amp; internal reviews;</td>
</tr>
<tr>
<td>Provide ongoing education on billing/coding &amp; compliance;</td>
</tr>
<tr>
<td>Respond promptly to audits &amp; reviews</td>
</tr>
<tr>
<td>Maintain copies of all documentation sent to auditors, follow-up;</td>
</tr>
<tr>
<td>Appeal when appropriate.</td>
</tr>
</tbody>
</table>
Mandatory Compliance Program

- The ACA requires providers to have a compliance program in place as a condition of enrollment in Medicare, Medicaid or CHIP
- CMS & OIG will establish the required core elements of the program
- CMS sought comment on 7 core elements & will publish specific proposals in the future

http://oig.hhs.gov/compliance/101/index.asp
7 Elements for Current Voluntary Compliance Program

1. Implementing written policies, procedures and standards of conduct.
2. Designating a compliance officer and compliance committee.
3. Conducting effective training and education.
4. Developing effective lines of communication.
5. Conducting internal monitoring and auditing.
7. Responding promptly to detected offenses and undertaking corrective action.

http://oig.hhs.gov/compliance
DECISION TREE FOR NEW & ESTABLISHED PATIENTS USING MEDICARE GUIDELINES

Received any professional services, i.e. e/m service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice within the previous three years?

Yes

Same physician specialty?

Yes

Established Patient

No

New Patient

No

New Patient
<table>
<thead>
<tr>
<th>Level of Appeal</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1st Level of Appeal</strong></td>
<td>60-day time limit</td>
</tr>
<tr>
<td>Redetermination</td>
<td>AIC*=$0</td>
</tr>
<tr>
<td>120 days to file appeal from date of receipt of prior determination</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>2nd Level of Appeal</strong></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reconsideration</td>
<td>AIC=$0</td>
</tr>
<tr>
<td>Qualified Independent Contractor</td>
<td></td>
</tr>
<tr>
<td>180 days to file appeal from date of receipt of prior determination</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>3rd Level of Appeal</strong></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative Law Judge Hearing</td>
<td>AIC≥$130†</td>
</tr>
<tr>
<td>60 days to file appeal from date of receipt of prior determination</td>
<td></td>
</tr>
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<table>
<thead>
<tr>
<th><strong>4th Level of Appeal</strong></th>
<th>Description</th>
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<tr>
<td>Appeals Council Review</td>
<td>90-day time limit</td>
</tr>
<tr>
<td>60 days to file appeal from date of receipt of prior determination</td>
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<tr>
<th><strong>5th Level of Appeal</strong></th>
<th>Description</th>
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<tbody>
<tr>
<td>Judicial Review US District Court</td>
<td>AIC≥$1,300*</td>
</tr>
<tr>
<td>60 days to file appeal from date of receipt of prior determination</td>
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</tbody>
</table>

*All evidence must be submitted at the reconsideration level or sooner, absent good cause for late filing of evidence.

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*AIC=amount in controversy. †2012 AIC amounts.
Overview

The Centers for Medicare & Medicaid Services (CMS) implemented the Comprehensive Error Rate Testing (CERT) program to measure improper payments in the Medicare fee-for-service (FFS) program. CERT is designed to comply with the Improper Payments Elimination and Recovery Act of 2002 (IPERA), Public Law 111-204. The Department of Health and Human Services (HHS) Office of Inspector General (OIG) estimated the Medicare FFS error rate from 2005 through 2008. The OIG designed its sampling method to estimate a national Medicare FFS paid claims error rate. Due to the sample size--approximately 6,000 claims--the OIG was unable to produce error rates by contractor type, specific contractor, service type, or provider type. Following recommendations from the OIG, the sample size increased for the CERT program when CMS began producing the Medicare FFS error rate for the November 2009 Report. This methodology includes CERT randomly selecting a sample of approximately 60,000 claims submitted to Carriers, FIs, and MACs during each reporting period. Requesting medical records from the health care providers that submitted the claims in the sample. Where medical records were submitted by the provider, reviewing the claims in the sample and the associated medical records to see if the claims complied with Medicare coverage, coding, and billing rules. If not, assigning errors to the claims. Where medical records were not submitted by the provider, classifying the case as a no documentation claim and counting it as an error. Sending providers overpayment letters/notifications or making adjustments for claims that were overpaid or underpaid. The CERT program cannot be considered a measure of fraud. Since the CERT program uses random samples to select claims, reviewers are often unable to see provider billing patterns that indicate potential fraud when making payment determinations. The CERT program does not, and cannot, label a claim fraudulent. All public reports produced by the CERT program are available through the “CERT Reports” link on the section navigation bar to the left.

Downloads:

CERT 101 Presentation (PDF, 523 KB)
Overview of Improper Payment Reviews (PDF, 275 KB)
Electronic Submission of Medical Documentation (ESMD) Introduction (PDF, 623 KB)
Related Links inside CMS

2011 Original Medicare Improper Payments Error Rate
Medicare Claim Review Programs: MR, NCCI Edits, MDMs, CERT and Recovery Audit Program
CMS Fact Sheets
CMS Press Releases
Press Release: NEW STANDARDS HELPING LOWER MEDICARE IMPROPER PAYMENT RATES FOR 2012
Press Release: HHS EMPLOYS NEW TOUGHER STANDARDS IN CALCULATION OF IMPROPER MEDICARE PAYMENT RATES FOR 2009

www.cms.gov/cert/
Resources

CMS  E/M Documentation Resources

CMS Distribution of E/M Services by Specialty
Resources

OIG Work Plans
http://oig.hhs.gov/publications/workplan.asp

OIG Physician Compliance Plan
http://oig.hhs.gov/authorities/docs/physician.pdf

OIG Avoiding Medicare/Medicaid Fraud & Abuse

CMS Provider Compliance Webpage
www.cms.gov/MLNProducts/45_ProviderCompliance.asp
Resources

CMS Change Request (CR) 6698
MLN Fact Sheet Signature Requirements
www.cms.gov/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf
CMS Internet Only Manual (IOM) Publication100-8; Chapter 3, Section 3.4.1.1
www.cms.gov/manuals/downloads/pim83c03.pdf
CERT Report
Resources

- OIG Work Plan & Reports
  www.oig.hhs.gov
- CERT Reports
  www.cms.hhs.gov/cert
- GAO Reports
  www.gao.gov
- RAC Evaluation Reports
- Medicare Claim Review Programs Booklet
“Incident To” Resources

Medicare Benefit Policy Manual Chapter 15

Medicare Claims Processing Manual Chapter 12

CMS MLN Matters article SE0441
'Incident' to Services
Other Resources

MGMA Oncology Practice Resources
www.mgma.com/oncology/

American Society of Clinical Oncology
www.asco.org

Association of Community Cancer Centers
www.accc-cancer.org

American Medical Association
www.ama-assn.org