CMS Approved Audit Issues

Updated February 2023

Performant Recovery, Inc.

https://performantrac.com/

Region 1- NY, ME, NH, VT, MA, RI, CT, OH, KY, IN, and MI.
Region 5- National US Contract (DME/HHH)

Issue	Number	Description
Next Generation Sequencing: Medical Necessity and Documentation Requirements	0205	Effective for services performed on or after March 16, 2018, the Centers for Medicare & Medicaid Services (CMS) has determined that Next Generation Sequencing (NGS) as a diagnostic laboratory test is reasonable and necessary and covered nationally, when performed in a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory, when ordered by a treating physician, and when all of the National Coverage Determination (NCD) requirements are met. The documentation will be reviewed to determine if NGS as a diagnostic laboratory test was medically necessary according to the guidelines in the NCD.
Positron Emission Tomography (PET) for Initial Treatment Strategy in Oncologic Conditions: Medical Necessity and Documentation Requirements	0206	Fluorodeoxyglucose (FDG) Positron Emission Tomography (PET) is covered only in clinical situations in which PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal location to perform an invasive procedure. PET would also be considered reasonable and necessary when clinical management of the patient would differ depending on the staging of the cancer identified, and in clinical situations in which the stage of the cancer remains in doubt after completing a standard diagnostic workup or it is expected that conventional imaging study information is insufficient for clinical management of the patient. Medical records will be reviewed to determine if the utilization of FDG PET studies for initial anti-tumor treatment strategy are medically necessary according to Medicare coverage indications.
Trastuzumab (Herceptin), J9355 - Multi-Dose Vial Wastage, Dose vs. Units Billed	0036	Documentation will be reviewed to determine if the billed amount of trastuzumab (Herceptin) meets Medicare coverage criteria and applicable coding guidelines. Affected Codes: J9355. **HERCEPTIN®** (trastuzumab) is a Medicare covered drug used to treat HER2-overexpressing breast cancer and HER2- overexpressing metastatic gastric or gastroesophageal junction adenocarcinoma. **HERCEPTIN®** comes in a multi-use vial of 440 milligrams. A multi-use vial contains more than one individual dose of medication and is labeled as such by the manufacturer. The manufacturer supplies the drug containing the multi-use vial of 440 milligrams as well as a 20-milliliter vial of bacteriostatic water for reconstitution. When stored properly reconstituted **HERCEPTIN®** can be used for up to 28 days. For multi-use vials Medicare pays only for the amount administered to the beneficiary and does not pay for any discarded or wasted amount of drug.

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		HERCEPTIN® is dosed according to the patient's weight in kilograms multiplied by the dose prescribed by the physician in mg/kg to allow calculation of the actual dose that is to be administered. The claim must have the number of units actually administered to the patient as the number of units billed. The number of units billed can be rounded up to the next multiple of the HCPCS unit if the calculation results in a fraction of a unit. In the case of **HERCEPTIN®**, the HCPCS unit is 10mg. For example, if 144 mg was administered then 15 units should be noted on the claim as the amount billed. Providers insert the weight of the patient in kilograms and the number of mg/kg of the dose in the remarks field.
Not a New Patient	0039	Providers are only allowed to bill the CPT codes for New Patient visits if the patient has not received any face-to-face service from the physician or physician group practice (limited to physicians of the same specialty) within the previous 3 years. This query identifies claims for patients who have been seen by the same provider in the last 3 years but for which the provider is billing a new (instead of established) visit code. Findings are limited to line with overpayments only.
Office Visits Billed for Hospital Inpatients	0042	If evaluation and management service are being rendered to patients admitted to an inpatient hospital setting, then CPT Codes 99221-99223, 99231-99233 and 99238-99239 are to be used. CPT codes 99201-99215 are to be used for evaluation and management service provided in the physician's office, in an outpatient or other ambulatory facility.
New Patient Visits	0043	Identification of overpayments made when providers report visits with new-patient Evaluation and Management (E/M) codes for patients who do not meet the definition of a new patient. Claims are recouped when a provider bills a new-patient visit code and the same provider or a provider from the same group practice and with the same specialty has performed any other E/M services within a 3-year period of time.
Add-on Codes Paid without Primary Code and/or denied Primary Code	0050	CPT has designated certain codes as "add-on procedures". These services are always done in conjunction with another procedure and are only payable when an appropriate primary service is also billed
Outpatient Service Overlapping or During an Inpatient Stay	0072	Payment may not be made for outpatient services overlapping or during an inpatient stay.
Drugs and Biologicals Excessive or Insufficient Drug Units Billed	0074	Drugs and Biologicals should be billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed should be assigned based on the dosage increment specified in that HCPCS long descriptor and correspond to the actual amount of the drug administered to the patient, including any appropriate, discarded drug waste. If the drug dose used in the care of a patient is not a multiple of the HCPCS code dosage descriptor, the provider rounds to the next highest unit. Claims billed with excessive or insufficient units will be reviewed by a nurse, registered pharmacist, certified pharmacy technician, or certified coder to determine the actual amount administered and the correct number of billable/payable units. Affected Codes: C9025, C9295, J0129, J0178, J0256, J0583, J0585, J0894 J0897, J1300, J1459, J1561, J1566, J1569, J1572, j1745, J2323, J2353, J2357, J2505, J2778, J2796, J2997, J3101, J3262, J3487, J7325, J9033, J9035,

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Observation Evaluation & Management (E&M) codes billed Same Day as Inpatient Admission	0086	Medicare payment for the initial hospital visit includes all services provided to the patient on the date of admission by that physician, regardless of the site of service. The physician may not bill observation care codes (initial, subsequent and/or discharge management) for services on the date that he or she admits the patient to inpatient status.
Duplicate Payment- Exact	0091	Duplicate claims are any claims paid across more than one claim number for the same Beneficiary, CPT/HCPCS code and service date by the same provider. Affected Codes: All CPT, HCPCS Codes
Skilled Nursing Facility Consolidated Billing	0099	Payment for the majority of Skilled Nursing Facility (SNF) services provided to beneficiaries in a Medicare covered Part A SNF stay are included in a bundled prospective payment. Entities that provide these services should look to the SNF for payment. Under the consolidated billing requirement, the SNF must submit all Medicare. Affected Codes - See Appendix D.
Physician Services During Hospice Period	0105	Physician services billed during an active hospice period should be paid by the Hospice provider if services are related to the hospice beneficiary's terminal condition or if a physician is employed or paid under arrangement by the beneficiary's hospice provider. Medicare should not be billed for either of the aforementioned scenarios. Affected codes: Any codes except codes 90732, 90471, Q2034, G0008, G0009, G0010, 90460, 90461, 90472, 90655, 90656, 90657, 90661, 90662, 90673, 90685, 90686, 90687, 90688, Q2035, Q2036, Q2037, Q2038, Q2039, 90740, 90743, 90744, 90746, 90747, 90748
Consultation Services not covered under Part B	121	Based on Medicare Claims Processing Manual Chapter 12, Section 30.6.10, the consultation CPT codes 99241 through 99255 are no longer recognized for Medicare Part B payment. Physicians shall code patient evaluation and management visits with E/M codes that represent where the visit occurs and that identify the complexity of the visit performed. CPT codes 99241 through 99245 are overpayments and will be recovered.
Evaluation and Management (E&M) Same Day as Admission to a Nursing Facility	0132	CMS will not pay a physician for an emergency department visit or an office visit and a comprehensive nursing facility assessment on the same day. Bundle E/M visits on the same date provided in sites other than the nursing facility into the initial nursing facility care code when performed on the same date as the nursing facility admission by the same physician.
Therapeutic, Prophylactic, and Diagnostic Injections and Infusions: Documentation Requirements	0161	Documentation will be reviewed to determine if correct billing, coding, and medical necessity guidelines for Therapeutic, Prophylactic, and Diagnostic Injections and Infusions were met.
Erythropoiesis Stimulating Agents for Cancer Patients: Medical Necessity and Documentation Requirements	0171	Erythropoiesis stimulating agents (ESAs) stimulate the bone marrow to make more red blood cells and are United States Food and Drug Administration (FDA) approved for use in reducing the need for blood transfusion in patients with specific clinical indications. Medical records will be reviewed to determine if the use of ESA in cancer and related neoplastic conditions meets Medicare coverage criteria. Affected Codes J0881 and J0885 that were billed with modifiers EA and EB Applicable Policy References 1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements

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		for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party 4. 42 CFR §405.986- Good Cause for Reopening 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests 6. Medicare Benefit Policy Manual, Chapter 15, §50 Drugs and Biologicals 7. National Coverage Determinations (NCD) Manual, Chapter 1 Coverage Determinations, §110.21 Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions 8. Medicare Claims Processing Manual, Chapter 17 Drugs and Biologicals, §10 Payment Rules for Drugs and Biologicals, § 40 Discarded Drugs and Biologicals; §70 Claims Processing Requirements; §80.9 Required Modifiers for ESAs Administered to Non-ESRD Patients; and §80.12 Claim Processing Rules for ESAs Administered to Cancer Patients for Anti-Anemia Therapy 9. CGS Administrators, LLC, L34356, Erythropoiesis Stimulating Agents (ESA), Effective 10/01/2015; Revised 10/01/2018 10. WPS LCD L34633 Erythropoiesis Stimulating Agents – Epoetin alfa, Darbepoetin alfa, Peginesatide. Effective 10/01/2015; Revised 01/01/2019 11. FCSO LCD L36276 Erythropoiesis Stimulating Agents. Effective 01/01/2015; Revised10/01/2018 "
Bone Marrow or Stem Cell Transplant: Medical Necessity and Documentation Requirements	0181	Inpatient Hospital- This review will determine if a bone marrow or stem cell transplant was reasonable and necessary for the patient's condition based on the documentation in the medical record. Claims that do not meet the indications of coverage and/or medical necessity will be denied.

Cotiviti, LLC

http://www.cotiviti.com/RAC/Welcome

Region 2- MN, WI, IL, IA, MO, NE, KS, CO, NM, OK, TX, AR, LA, MS
Region 3- WV, VA, NC, SC, TN, AL, GA, FL

Issue	Number	Description
Prolonged Service Codes: Unbundling	0211	Per the 2019 and 2020 AMA CPT manuals, do not report CPT codes 99358 and/or 99359 during the same calendar month as CPT codes 99484, 99487, 99489, 99490, 99491, 99492, 99493, 99494. Dates of service affected will be 3 years prior to the informational letter date.
Next Generation Sequencing: Medical Necessity and Documentation Requirements	0205	Effective for services performed on or after March 16, 2018, the Centers for Medicare & Medicaid Services (CMS) has determined that Next Generation Sequencing (NGS) as a diagnostic laboratory test is reasonable and necessary and covered nationally, when performed in a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory, when ordered by a treating physician, and when all of the National Coverage Determination (NCD) requirements are met. The documentation will be reviewed to determine if NGS as a diagnostic laboratory test was medically necessary according to the guidelines in the NCD.

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Add-on Codes Paid without Primary Code and/or denied Primary Code	0050	CPT has designated certain codes as "add-on procedures". These services are always done in conjunction with another procedure and are only payable when an appropriate primary service is also billed
Initial Hydration, Infusion and Chemotherapy Administration	0071	When administering multiple infusions, injections or combinations, the physician should only report one "initial" service code unless protocol requires that two separate IV sites must be used. For these separate identifiable services, physicians need to report with using modifier 59, XE, XS, XP or XU.
Outpatient Service Overlapping or During an Inpatient Stay	0072	Payment may not be made for outpatient services overlapping or during an inpatient stay.
Drugs and Biologicals Excessive or Insufficient Drug Units Billed	0074	Drugs and Biologicals should be billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed should be assigned based on the dosage increment specified in that HCPCS long descriptor and correspond to the actual amount of the drug administered to the patient, including any appropriate, discarded drug waste. If the drug dose used in the care of a patient is not a multiple of the HCPCS code dosage descriptor, the provider rounds to the next highest unit. Claims billed with excessive or insufficient units will be reviewed by a nurse, registered pharmacist, certified pharmacy technician, or certified coder to determine the actual amount administered and the correct number of billable/payable units. Affected Codes: C9025, C9295, J0129, J0178, J0256, J0583, J0585, J0894 J0897, J1300, J1459, J1561, J1566, J1569, J1572, j1745, J2323, J2353, J2357, J2505, J2778, J2796, J2997, J3101,

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Duplicate Payment- Exact	0091	Duplicate claims are any claims paid across more than one claim number for the same Beneficiary, CPT/HCPCS code and service date by the same provider. Affected Codes: All CPT, HCPCS Codes
Facility vs. Non-Facility Reimbursement	0108	Site of Service Payment Differential. Medicare Claims Processing Manual: Publication 100-04; Chapter 12, § 20.4.2: "The rate, facility or non-facility, that a physician service is paid under the MPFS is determined by the Place of service (POS) code that is used to identify the setting where the beneficiary received the face-to-face encounter with the physician, nonphysician practitioner (NPP) or other supplier. In general, the POS code reflects the actual place where the beneficiary receives the face-to-face service and determines whether the facility or non-facility payment rate is paid. However, for a service rendered to a patient who is an inpatient of a hospital (POS code 21) or an outpatient of a hospital (POS codes 19 or 22), the facility rate is paid, regardless of where the face-to-face encounter with the beneficiary occurred."
Consultation Services not covered under Part B	121	Based on Medicare Claims Processing Manual Chapter 12, Section 30.6.10, the consultation CPT codes 99241 through 99255 are no longer recognized for Medicare Part B payment. Physicians shall code patient evaluation and management visits with E/M codes that represent where the visit occurs and that identify the complexity of the visit performed. CPT codes 99241 through 99245 are overpayments and will be recovered.
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HMS Federal Solutions (Retired) - Cotiviti

https://rac4info.cotiviti.com/

Region 4- ND, SD, MT, WY, ID, WA, OR, AK, CA, NV, UT, AZ

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Resources

Medicare Fee for Service Recovery Audit Program

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/

Medicare Fee for Services RAC Regions

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Medicare-FFS-RAC-map-November-2016-clean.pdf