

MEDICARE QUARTERLY PROVIDER COMPLIANCE NEWSLETTER

Guidance to Address Billing Errors

Volume 11, Issue 1



PRINT-FRIENDLY VERSION

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[Archive of previous Medicare Quarterly Provider Compliance Newsletters](#)

INTRODUCTION

Learn about avoiding common billing errors and other erroneous activities when dealing with the Medicare Fee-For-Service (FFS) Program. This newsletter includes guidance to help health care professionals address and avoid the top issues of the particular quarter.

There are more than one billion claims processed for the Medicare FFS program each year. Medicare Administrative Contractors (MACs) process these claims, make payments to more than one million health care professionals in accordance with Medicare regulations, and provide education on how to submit accurately coded claims.

Despite actions to prevent improper payments, it is impossible to prevent them all due to the large volume of claims. The Medicare Learning Network's® Medicare Quarterly Provider Compliance Newsletter helps health care professionals to understand the latest findings identified by MACs and other contractors such as Recovery Auditors and the Comprehensive Error Rate Testing (CERT) review contractor, in addition to other governmental organizations such as the Office of the Inspector General (OIG).

The Centers for Medicare & Medicaid Services (CMS) releases the newsletter on a quarterly basis. An [archive](#) of previously-issued newsletters, which includes keyword and provider-specific indices, is available on the CMS website.



Physicians



Non-Physician
Practitioners



Providers



Durable Medical
Equipment Suppliers

RECOVERY AUDITOR FINDING - A REMINDER: NEW ISSUE #0070- CRITICAL CARE BILLED ON THE SAME DAY AS EMERGENCY ROOM SERVICES: UNBUNDLING**PHY NPP****Provider Types Affected: Physicians, Non-Physician Practitioners (NPPs)**

Problem Description: Hospital emergency department services are not payable for the same calendar date as critical care services when billed for the same beneficiary, on the same date of service and by the same service provider (based on Tax ID and Provider Specialty Code). Affected codes: 99281, 99282, 99283, 99284, 99285.

This automated review may recoup payment for emergency room Evaluation & Management codes when billed for the same beneficiary, on the same date of service and same service provider (based on Tax ID and Provider Specialty Code), as either of the critical care service codes 99291 or 99292.

Emergency Services CPT code guidelines:

Current Procedural Terminology (CPT) codes 99281-99285 are all emergency department visits for the Evaluation and Management (E/M) of a patient in the emergency department, **excluding** critical care services. No distinction is made between new and established patients in the emergency department. An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.

CPT codes 99291 and 99292 are critical care codes used in the emergency department or other places in the hospital.

CPT code 99291 is used to report the first 30 - 74 minutes of critical care on a given calendar date of service. It should only be used once per calendar date per patient by the same physician or physician group of the same specialty. **Note:** Critical care of less than 30 minutes total duration on a given calendar date is not reported separately using the critical care codes. This service should be reported using another appropriate E/M code such as subsequent hospital care.

CPT code 99292 is used to report additional block(s) of time, of up to 30 minutes each beyond the first 74 minutes of critical care.

Physicians in the same group practice who have the same specialty may not each report CPT initial critical care code 99291 for critical care services to the same patient on the same calendar date. Medicare payment policy states that physicians in the same group practice who are in the same specialty must bill and be paid as though each were the single physician.

Medicare Policy:

1. Hospital emergency department services are not paid for the same date as critical care services when provided by the same physician to the same patient. (See the Medicare Claims Processing Manual, [Chapter 12](#), Section 30.6.9.A)
2. Medicare advises physicians and qualified NPPs to retain documentation for discretionary review by the Medicare Administrative Contractor (MAC) should claims be questioned for both hospital care and critical care claims. The retained documentation must support claims for critical care when the same physician or physicians of the same specialty in a group practice report critical care services for the same patient on the same calendar date as other E/M services. (See the Medicare Claims Processing Manual, [Chapter 12](#), Section 30.6.9.A)
3. **Initial Hospital Care from Emergency Room:** MACs pay for an initial hospital care service if a physician sees a patient in the emergency room and decides to admit the person to the hospital. They do not pay for both E/M services. Also, they do not pay for an emergency department visit by the same physician on the same date of service. When the patient is admitted to the hospital via another site of service; for example hospital emergency department, physician's office, or nursing facility; all services the physician provides in conjunction with that admission are part of the initial hospital care when performed on the same date as the admission date. (See the Medicare Claims Processing Manual, [Chapter 12](#), Section 30.6.9.1.A)
4. **Critical Care Services and Other E/M Services Provided on Same Day:** When the patient requires critical care services upon presentation to the hospital emergency department, only report critical care codes 99291 - 99292. Do not also report an emergency department visit code. (See the Medicare Claims Processing Manual, [Chapter 12](#), Section 30.6.12.H)
5. When physicians provide critical care services on a date where an inpatient hospital, office, or outpatient E/M was furnished earlier on the same date at which time the patient did not require critical care, Medicare will allow and pay for both the critical care and the previous E/M service. (See the Medicare Claims Processing Manual, [Chapter 12](#), Section 30.6.12.H)
6. Medically necessary critical care services provided on the same calendar date to the same patient by physicians representing different medical specialties that are not duplicative services are payable. The medical specialists may be from the same group practice or from different group practices. Critically ill or critically injured patients may require the care of more than one physician medical specialty. Concurrent critical care services provided by each physician must be medically necessary and not provided during the same instance of time. (See the Medicare Claims Processing Manual, [Chapter 12](#), Section 30.6.12.I)

Clinical Example of Correct Billing of Time: A patient arrives in the emergency department in cardiac arrest. The emergency department physician provides 40 minutes of critical care services. A cardiologist is called to the emergency department and assumes responsibility for the patient, providing 35 minutes of critical care services. The patient stabilizes and is transferred to the Critical Care Unit (CCU). In this instance, the emergency department physician provided 40 minutes of critical care services and reports only the critical care code (CPT code 99291) and **does not report codes for emergency department services**. Using CPT code 99291, the cardiologist may also report the 35 minutes of critical care services provided in the emergency department. You report additional critical care services by the cardiologist in the CCU (on the same calendar date) using 99292 or another appropriate E/M code depending on the clock time involved. (See the Medicare claims Processing Manual, [Chapter 12](#), Section 30.6.12.F)

Resources:

You may want to review the following information to help avoid errors regarding the reporting of critical care and emergency department services:

- Medicare Claims Processing Manual, Chapter 12, Section 30.6.9 and Section 30.6.9.1, which is at <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf>
- Medicare Claims Processing Manual: Chapter 12, Section 30.6.12, Sections F, H, and I, which is at <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf>
- MLN Matters Article, MM5993, Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292) <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5993.pdf>
- 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>



RECOVERY AUDITOR FINDING - A REMINDER: NEW ISSUE #0131- PNEUMATIC COMPRESSION DEVICE (PCD): MEDICAL NECESSITY AND DOCUMENTATION REQUIREMENTS

Provider Types Affected: Durable Medical Equipment (DME) Suppliers, including physicians who supply DME

Problem Description: When providing Pneumatic Compression Devices (PCDs) to patients, be sure the patient meets all Medicare coverage criteria. Recovery Auditors perform complex reviews on claims for these devices to determine if the PCD is 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. Affected codes are E0650, E0651, E0652, E0656, E0657, E0667, E0668, E0669 and E0670.

Pneumatic compression devices consist of an inflatable garment for the arm or leg and an electrical pneumatic pump that fills the garment with compressed air. The garment is intermittently inflated and deflated with cycle times and pressures that vary between devices. Medicare covers pneumatic devices for the treatment of lymphedema or for the treatment of Chronic Venous Insufficiency (CVI) with venous stasis ulcers. (See the [National Coverage Determination Manual \(NCD\) 280.6](#))

Lymphedema is the swelling of subcutaneous tissues due to the accumulation of excessive lymph fluid. The accumulation of lymph fluid results from impairment to the normal clearing function of the lymphatic system and/or from an excessive production of lymph. Lymphedema is divided into two broad classes according to etiology. Primary lymphedema is a relatively uncommon, chronic condition which may be due to such causes as Milroy's Disease or congenital anomalies. ([NCD 280.6](#))

Secondary lymphedema, which is much more common, results from the destruction of or damage to formerly functioning lymphatic channels, such as surgical removal of lymph nodes or post radiation fibrosis, among other causes. ([NCD 280.6](#)) It is most commonly caused by surgery (especially lymph node dissection, such as for breast cancer), radiation therapy (especially axillary or inguinal), trauma, lymphatic obstruction by tumor, and, in developing countries, lymphatic filariasis. Secondary lymphedema may also result from compression of the lymphatic and venous channels resulting from leakage of fluid into interstitial tissues in patients with chronic venous insufficiency. ([LCD L33829](#))

Chronic Venous Insufficiency (CVI) of the lower extremities is a condition caused by abnormalities of the venous wall and valves, leading to obstruction or reflux of blood flow in the veins. Signs of CVI include hyperpigmentation, stasis dermatitis, chronic edema, and venous ulcers. ([NCD 280.6](#))

CODE	DESCRIPTION
E0650	PNEUMATIC COMPRESSOR, NON-SEGMENTAL HOME MODEL
E0651	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITHOUT CALIBRATED GRADIENT PRESSURE
E0652	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITH CALIBRATED GRADIENT PRESSURE
E0656	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, TRUNK
E0657	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, CHEST
E0667	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL LEG
E0668	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM
E0669	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG
E0670	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, INTEGRATED, 2 FULL LEGS AND TRUNK

Medicare Policy:

- Medicare covers PCDs in the home setting for the treatment of lymphedema if the patient has undergone a 4-week trial of conservative therapy and the treating physician determines that there has been no significant improvement or if significant symptoms remain after the trial. The trial of conservative therapy must include use of an appropriate compression bandage system or compression garment, exercise, and elevation of the limb. The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression. (See the [\(NCD\) 280.6](#))
- Medicare covers PCDs in the home setting for the treatment of CVI of the lower extremities only if the patient has one or more venous stasis ulcer(s) which have failed to heal after a 6-month trial of conservative therapy directed by the treating physician. The trial of conservative therapy must include a compression bandage system or compression garment, appropriate dressings for the wound, exercise, and elevation of the limb. [\(NCD 280.6\)](#)

- The only time Medicare covers a segmented, calibrated gradient PCD (HCPCS code E0652) is when the individual has unique characteristics that prevent them from receiving satisfactory pneumatic compression treatment using a non-segmented device in conjunction with a segmented appliance or a segmented compression device without manual control of pressure in each chamber. ([NCD 280.6](#))

General Coverage Criteria ([NCD 280.6](#))

Medicare covers PCDs only when prescribed by a physician when the physician uses appropriate oversight to:

- evaluate the patient's condition to determine medical necessity of the device
- assure suitable instruction in the operation of the machine
- provide a treatment plan defining the pressure to be used and the frequency and duration of use
- monitor use and response to treatment on an ongoing basis

The determination by the physician of the medical necessity of a PCD device must include:

- The patient's diagnosis and prognosis
- Symptoms and objective findings, including measurements which establish the severity of the condition
- The reason the device is required, including the treatments which have been tried and failed
- The clinical response to an initial treatment with the device

Note: The clinical response includes the change in pretreatment measurements, ability to tolerate the treatment session and parameters, and ability of the patient (or caregiver) to apply the device for continued use in the home.

Documentation Requirements

The medical record must meet the documentation requirements as outlined in the Local Coverage Articles, [A55426](#) and [A52488](#)

Medical Necessity Requirements

E0650, E0651 for Lymphedema ([LCD L33829](#))

- Used to treat lymphedema, when meeting the following requirements:
 - Has a diagnosis of lymphedema as defined above
 - The persistence of chronic and severe lymphedema as identified by the documented presence of **at least one** of the following clinical findings:
 - Marked hyperkeratosis with hyperplasia and hyperpigmentation,
 - Papillomatosis cutis lymphostatica,
 - Deformity of elephantiasis,
 - Skin breakdown with persisting lymphorrhea,

- Detailed measurements over time confirming the persistence of the lymphedema with a history evidencing a likely etiology, and
- In addition to this documented persistence, the lymphedema is then documented to be unresponsive to other clinical treatment over the course of a required four-week trial.
 - The four-week trial of conservative therapy must include **ALL** of the following:
 - Regular and compliant use of an appropriate compression bandage system or compression garment to provide adequate graduated compression
 - Adequate compression is defined as (1) sufficient pressure at the lowest pressure point to cause fluid movement, and (2) sufficient pressure across the gradient (from highest to lowest pressure point) to move fluid from distal to proximal. The compression used must not create a tourniquet effect at any point.
 - The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression starting with a minimum of 30 mmHg distally.
 - Regular exercise
 - Elevation of the limb

Note: When available, manual lymphatic drainage is a key component of conservative treatment as is appropriate medication treatment when there is concurrent congestive failure.

Note: At the end of the four-week trial, if there has been improvement, then reimbursement for a PCD is not justified. Where improvement has occurred, the trial of conservative therapy must be continued with subsequent reassessment at intervals at least a week apart. At a minimum, re-assessments conducted for a trial must include detailed measurements, obtained in the same manner and with reference to the same anatomic landmarks, prior to and at the conclusion of the various trials and therapy, with bilateral comparisons where appropriate.

Only when no significant improvement has occurred in the most recent four weeks and the coverage criteria above are still met, may the lymphedema be considered unresponsive to conservative therapy, and coverage for a PCD considered.

Note: The trial of conservative therapy must be documented in the beneficiary's medical record before prescribing any type of pneumatic compression device (E0650, E0651). This assessment may be performed by the treating practitioner or any other Licensed/Certified Medical Professional (LCMP) directly involved in the beneficiary's lymphedema treatment. The LCMP may not have any financial relationship with the DMEPOS supplier providing the device. If the assessment is performed by an LCMP, the treating practitioner must receive and review the report of the evaluation. In addition, the treating practitioner must sign and date the report,



and state concurrence or disagreement with the assessment. The signature date must be on or before the prescription date.

Note: E0650 or E0651 used to treat edema from causes other than lymphedema is not eligible for reimbursement. Claims will be denied as not reasonable and necessary.

E0650, E0651 for Chronic Venous Insufficiency with Venous Stasis Ulcers (CVI) ([LCD L33829](#))

- is covered for the treatment of CVI of the lower extremities only if the patient has **ALL** of the following:
 - Edema in the affected lower extremity
 - One or more venous stasis ulcer(s)
 - Note: E0650 or E0651 used to treat ulcers in locations other than the lower extremity or ulcers and wounds from other causes is not eligible for reimbursement. Claims will be denied as not reasonable and necessary.
 - The ulcer(s) have failed to heal after a six-month trial of conservative therapy directed by the treating practitioner.
 - The six-month trial of conservative therapy must include all of the following:
- Compliant use of an appropriate compression bandage system or compression garment to provide adequate graduated compression
 - Adequate compression is defined as (1) sufficient pressure at the lowest pressure point to cause fluid movement and (2) sufficient pressure across the gradient (from highest to lowest pressure point) to move fluid from distal to proximal. The compression used must not create a tourniquet effect at any point.
 - The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression starting with a minimum of 30 mmHg distally.
- Medications as appropriate (e.g. diuretics and/or other treatment of congestive failure, etc.)
- Regular exercise
- Elevation of the limb
- Appropriate wound care for the ulcer (including sharp debridement where appropriate)

Note: At the end of the six-month trial, if there has been improvement, then reimbursement for a PCD is not reasonable and necessary. Where improvement has occurred, the trial of conservative therapy must be continued with subsequent reassessments. When no significant improvement has occurred for a continuous period of six months and the coverage criteria above are still met, then the use of a PCD to treat CVI is eligible for reimbursement.

Note: The trial of conservative therapy must be documented in the beneficiary's medical record before prescribing any type of pneumatic compression device (E0650, E0651). This assessment may be performed by the treating practitioner or any other licensed/certified medical professional (LCMP) directly involved in the beneficiary's CVI treatment. The LCMP may not have any financial relationship with the DMEPOS supplier providing the device. If the assessment is performed by an LCMP, the treating practitioner must receive and review the report of the evaluation. In addition, the treating practitioner must

sign and date the report, and state concurrence or disagreement with the assessment. The signature date must be on or before the prescription date.

E0652 for Lymphedema extending onto the Chest, Trunk, and/or Abdomen ([LCD L33829](#))

- is covered for the treatment of lymphedema extending onto the chest, trunk and/or abdomen when **ALL** of the following are met:
 - The beneficiary has lymphedema of an extremity as defined above
 - The coverage criteria for an E0650 or E0651 are met
 - The beneficiary has lymphedema extending onto the chest, trunk and/or abdomen that extends past the limits of a standard compression sleeve, and the chest, trunk and/or abdominal lymphedema has failed to improve with a four-week trial.
 - A four-week trial of conservative therapy demonstrating failed response to treatment with an E0650 or E0651 is required. The four-week trial of conservative therapy must include all of the following:
 - At least four weeks of regular, daily, multiple-hour home usage of the E0650 or E0651 after careful, in-person fitting, training and supervision by a technician who is skilled in and who regularly and successfully uses the appliance provided
 - Compliant use of an appropriate compression bandage system or compression garment to provide adequate graduated compression
 - Adequate compression is defined as (1) sufficient pressure at the lowest pressure point to cause fluid movement and (2) sufficient pressure across the gradient (from highest to lowest pressure point) to move fluid from distal to proximal. The compression used must not create a tourniquet effect at any point.
 - The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression starting with a minimum of 30 mmHg distally.
 - Regular exercise
 - Elevation where appropriate
 - Manual lymphatic drainage (where available) and self-manual lymphatic drainage (MLD) for at least 30 minutes per day
 - Evaluation of diet and implementation of any necessary change
 - Medications as appropriate (e.g. diuretics and/or other treatment of congestive failure, etc.)
 - Correction (where possible) of anemia and/or hypoproteinemia

Note: Where improvement has occurred, the trial of conservative therapy must be continued with subsequent reassessment at intervals at least a week apart. When and only when no significant improvement has occurred in the most recent four weeks and the coverage criteria above are still met, an E0652 is eligible for reimbursement.

Note: The trial of conservative therapy must be documented in the beneficiary's medical record before prescribing any type of pneumatic compression device (E0652). This assessment may be performed by the treating practitioner or any other licensed/certified medical professional (LCMP) directly involved in the beneficiary's lymphedema treatment. The LCMP may not have any financial relationship with the DMEPOS supplier providing the device. If the assessment is performed by an LCMP, the treating practitioner must receive and review the report of the evaluation. In addition, the treating practitioner must sign and date the report, and state concurrence or disagreement with the assessment. The signature date must be on or before the prescription date.

Note: E0652 is not covered for the treatment of CVI even if the criteria in this section are met. Claims will be denied as not reasonable and necessary.

PCD related accessories (E0655, E0656, E0657, E0660, E0665, E0666, E0667, E0668, E0669, E0670, E0671, E0672, E0673) are eligible for reimbursement only when the appropriate, related base PCDs (E0650, E0651, E0652, E0675) meets the applicable coverage criteria for that type of PCD. If the base PCD is not covered, related accessories are not eligible for reimbursement and Medicare will deny such claims as not reasonable and necessary. ([LCD L33829](#))

Resources:

You may want to review the following information to help avoid documentation and medical necessity errors when prescribing PCDs:

- Medicare National Coverage Determination Manual, Chapter 1, Part 4, Section 280.6, Pneumatic Compression Devices https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_part4.pdf
- CGS Administrators, LLC, and Noridian Healthcare Solutions, LLC, LCD L33829 – Pneumatic Compression Devices; Effective 10/01/2015; Revised 01/01/2020 <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33829>
- CGS Administrators, LLC, and Noridian Healthcare Solutions, LLC, Local Coverage Article A52488- Pneumatic Compression Devices- Policy Article; Effective 10/01/2015; Revised 01/01/2020 <https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52488>
- CGS Administrators, LLC, and Noridian Healthcare Solutions, LLC, Local Coverage Article A55426- Standard Documentation Requirements for All Claims Submitted to DME MACs; Effective 01/01/2017; Revised 04/06/2020 <https://calmedmedical.com/wp-content/uploads/2018/11/A55426.pdf>
- 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>