Medicare Learning Network®
Official CMS Information for Medicare Fee-For-Service Providers

MLN PROVIDER COMPLIANCE FAST FACT ARCHIVE

Medicare Learning Network® (MLN) Provider Compliance monthly fast facts are designed to highlight relevant tips and corrective actions in an effort to help Medicare Fee-For-Service Providers understand and comply with Medicare policy.

The fast facts listed on this page were posted on the MLN Provider Compliance web page during the months indicated below. This list will be updated as new fast facts are posted.

FAST FACT	DATE
The Medicare Learning Network® (MLN) has released a new package of products designed to educate physicians and other Medicare and Medicaid providers about medical identity theft and strategies for addressing it. These products include a web-based training course that is approved for Continuing Education (CE) credit. For more information, scroll down to the Downloads section and click on the 'Medicaid Program Integrity: Safeguarding Your Medical Identity Educational Products' link.	August 2012
Are you billing correctly for ordered/referred services? Will you be impacted when CMS turns on the edits for these services? See MLN Matters® articles #SE1221, #SE1011, and the MLN fact sheets "Medicare Enrollment Guidelines for Ordering/Referring Providers" and "The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement" to learn what you need to do.	July 2012
Did the medical records support the service billed on your claim selected by the CERT, Recovery Auditors (RA), or Medicare contractor(s), but you still received an error? Were some of the documents missing from your original response to the documentation request which caused the claim to be in error? If you receive an error on a claim selected by the CERT, RA or Medicare contractor, please review the medical records and determine if you agree with the results. If you disagree, you can appeal with your local Medicare contractor using the normal appeal process. Visit your local Medicare contractor's website for any appeal forms and appeal process. To find your local Medicare contractors contact information and website address, please visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-	June 2012

MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website. For more information about the Medicare Part A and Part B administrative appeals process, please refer to the Medicare Learning Network® brochure "The Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers".	
The condition chiefly responsible for a patient's admission to the hospital should be sequenced as the principal diagnosis. Code only those conditions documented by the physician. Refer to the Medicare Learning Network (MLN)® fact sheet "Present on Admission (POA) Indicator Reporting by Acute Inpatient Prospective Payment System (IPPS) Hospitals" for more information.	May 2012
Medicare is denying an increasing number of claims, because providers are not identifying the correct primary payer prior to claims submission. Medicare would like to remind providers, physicians, and suppliers that they have the responsibility to bill correctly and to ensure claims are submitted to the appropriate primary payer. Please refer to the "Medicare Secondary Payer (MSP) Manual", Chapter 3, and MLN Matters® Article #SE1217 for additional guidance.	April 2012
When coding for an inpatient hospital stay, the diagnostic and procedural information and the beneficiary's discharge status (as the hospital coded and reported on its claim) must match both the attending physician description and the information contained in the beneficiary's medical record. Please review the "ICD-9-CM Official Guidelines for Coding and Reporting" and the "Medicare Claims Processing Manual", Chapter 6 to ensure complete and accurate coding.	March 2012
Does your documentation support the medical need for the service rendered? The documentation may include clinical evaluations, physician evaluations, consultations, progress notes, physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. It is maintained by the physician and/or provider. For more information, please refer to the "Program Integrity Manual", Pub 100-08, Chapter 3, Section 3.2.3 A.	February 2012
PROBLEM: Recovery Auditors found that suppliers bill for Positive Airway Pressure (PAP) and Respiratory Assist Device (RAD) accessories in quantities that exceed the determined medically-necessary amounts. **SOLUTION:** Suppliers can avoid overpayment by developing or enhancing edits to identify DME claims when there is overutilization of PAP/RAD accessories. Some audits are most efficiently handled through post-pay review. For additional guidance, please refer to MLN Matters® Article #MM6048 and "Medicare National Coverage Determination Manual," Chapter 1, Section 240.4.	January 2012
In order for Medicare to cover a power mobility device (PMD), the supplier must receive the written prescription within 45 days of a face-to-face examination by the treating physician, or discharge from a hospital or nursing home, and before the PMD is delivered. The date of service on the claim must be the date the PMD device is furnished to the patient. A PMD cannot be delivered based on a verbal order. If the supplier delivers the item prior to receipt of a written prescription, the PMD will be denied as noncovered.	November 2011

For more details, please refer to the Medicare Learning Network® fact sheet on this topic titled, "Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements".	
A Medicare overpayment is a payment made to a physician or supplier that exceeds amounts due and payable under Medicare statute and regulations. Once the overpayment is determined, the amount becomes a debt owed by the debtor to the Federal government. Federal law requires CMS to seek the recovery of all identified overpayments. For more information about the Medicare overpayment collection process, please download the Medicare Learning Network® fact sheet titled "The Medicare Overpayment Collection Process".	September 2011
Issue: Outpatient Rehabilitation Services – Medical Record Documentation and Claims Submission CERT Errors **Solution:** The medical record should clearly document: • Complete plan of care; • Date the plan of care is modified, including how it was modified and why the previous goals were not met or could not be met; • Confirmation that the plan of care is certified (recertified when appropriate) with physician/ NPP signature and date; and • Treatment time for timed codes and total treatment time (including timed and untimed codes).	July 2011
Issue: Evaluation and Management (E/M) Services **Solution:** For documentation guidelines pertaining to E/M services, visit http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp on the CMS website.	June 2011
Issue: Inpatient Rehabilitation Admission **Solution:** Be sure your inpatient rehabilitation admission is reasonable and necessary. Verify and document that the patient requires, can tolerate, and can significantly benefit from an intensive rehabilitation therapy program delivered in a hospital inpatient setting. Please refer to the "Medicare Benefit Policy Manual" (IOM 100-02), Chapter 1, Section 110, for more information.	May 2011