

TO: ALL PROVIDERS

FROM: CAREFIRST OF MARYLAND INC., MEDICARE PART A

DATE: June 20, 2005

**SUBJECT: MEDICAL REVIEW ISSUES REGARDING
ECHOCARDIOGRAPHY SERVICES**

The purpose of this bulletin is to clarify proper billing of outpatient Echocardiography services. CareFirst of MD Inc., Medicare Part A Fiscal Intermediary has an active medical policy edit in place to review Echocardiography services based on criteria outlined in our Local Coverage Determination (LCD) Policy Number 03-03.

CareFirst recently completed data analysis of the use of HCPCS 99303-93350 (revenue code 48X). Coding irregularities were identified with multiple providers resulting in a significant error rate. The following billing issues were identified:

- Non-receipt of medical records
- Service billed does not match procedural code description
- Services not documented
 - Medical record entries not signed
 - Draft report sent instead of finalized report with physician interpretation
- Noncovered diagnosis per LCD
- No MD order/No MD supervision, evaluation/No MD cert
- Not reasonable/medically necessary
- Denied services included in other services billed

In an effort to reduce the number of denied claims, as well as decrease the intermediary appeal volume, we have included an LCD and coding parameters on our web site. Our web site can be accessed at http://www.marylandmedicare.com/pages/mdmedicare/local/active/active_policies_list.htm

Services billed with a diagnosis code that is not listed in the Covered Diagnosis Codes section of this policy will be denied as not medically necessary. The beneficiary will not be held financially liable unless an Advance Beneficiary Notice (ABN) is obtained.

All of the coverage criteria included in the LCD must be met before echocardiography services can be reimbursed by Medicare.

Diagnosis (es) must be present on any claim submitted and must be coded to the highest level of specificity. The diagnosis codes(s) must be representative of the patient's condition.

Records not received within the allotted 45 days, (56900 denials) are a significant source of claims error. The date contained on the top left hand corner of the ADR begins the clock for the allowed forty-five days to submit these records to CareFirst of MD, Inc. Facilities should standardize their procedures beginning with the receipt of their mail to insure proper routing for ADRs, as many providers fail to receive the original ADR in the appropriate department.

Facilities should also consider increased monitoring of submitted claims. Monitoring of the Medical Review suspense location in the FISS system (represented by claims in SB6001) should identify claims suspended for requested records. More stringent monitoring will alert providers to records submitted but not yet received by CareFirst of MD, Inc.

Submitting ALL requested documentation is the key to avoiding 54018 (services not documented) denials. Title XVIII of the Social Security Act, section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim. Please note that facilities should submit all of the information in the ADR. The requested information is medically reviewed to insure that the claim is paid correctly in compliance with Medicare guidelines. If any information necessary to review the claim is not submitted, the claim will be partially or fully denied as indicated by the review.

CareFirst's Additional Development Request (ADR) letter includes a list of medical record components that need to be submitted. These include:

1. Medical record showing chief complaint, history of past and present illness, physical examination and medical necessity of service.
2. Physician's order for echocardiography services.
3. Report of service with physician interpretation.
4. Itemized bill for all services billed on claim.

Facilities should be familiar with all information resources available to them such as LCDs, NCDs, CMS Manuals, transmittals, change requests, etc. The national CMS and local contractor websites should be reviewed often and all information forwarded to applicable departmental personnel. A final audit process prior to records submission - having qualified personnel review records to be sent as a final step prior to submitting the records - can insure that correct dates of service, complete diagnoses lists, and other requested items contained on the ADR, are accurately reflected. This would help eliminate unnecessary denials that count toward your overall claims payment error rate and that may result in a more intensive level of medical review. Providers are encouraged to keep a copy of the records they submit to Medicare in order to quickly see what was actually sent.

Our overall goal is to ensure proper billing practices so that claims will be submitted and paid correctly.

Any questions should be addressed to your Provider Representative at 1-866-488-0545. Medical Review will closely monitor submission of these codes for correct format.

THIS BULLETIN SHOULD BE SHARED WITH ALL HEALTH CARE PRACTITIONERS AND MANAGERIAL MEMBERS OF THE PROVIDER/SUPPLIER STAFF. BULLETINS ARE AVAILABLE AT NO COST FROM OUR WEBSITE AT www.marylandmedicare.com.