

RAC Approved Audit Issues

Issue	Summary	CPT Codes	Citation	Region
Acute Hospital Readmissions without condition code B4 or 42	Discharge and readmission on same day for same DRG with no B4 or 42 condition code on second claim results in improper payment.	Multiple	CMS Claims Processing Manual 100-04, Chapter 3 §40.2.5 and 40.2.6, OIG Report A-03-01-00011, Change Request 3389 and Med Learn MM3389	C, D
Acute Inpatient Psychiatric Facility (IPF) – Source of Admission Code	Medicare makes an additional payment to an IPF or a distinct unit part (DPU) for the first day of a beneficiary’s stay to account for ED costs if the IPF has a qualifying ED. CMS does not make this payment if the patient was discharged from acute care section of a hospital to its own hospital based IPF. In this instance admission code “D” should be used to prevent an overpayment.	NA	OIG Report A-01-09-00504 dated May 2010; CMS CR 3881 dated October 21, 2005; MLN Matter MM3881 dated April 1, 2006; MLN Matter SE1020; Medicare Learning Fact Sheet - Inpatient Psychiatric Facility PPS dated May 2010 (ICN 006839); Claims Processing Manual (100-04), Chapter 3, Section 190.6.4.	D
Add On Codes	Overpayment for add on codes may occur if the primary procedure was not billed or denied.	Multiple	CMS Claims Processing Manual 100-04, Chapter 12 §30	A, B, C
Adenosine – Dose vs. Units Billed	Billing should be limited to 1 unit for every 30mg per date of service	J0152	Medlearn Matters Articles MM6323, MM5718 & CMS Transmittal R1669CP, AMA CPT Level II	C
AFO and KAFO Custom Fabricated v. Prefabricated Codes	HCPCS for AFO and KAFO additions that include the descriptors “For Custom Fabricated Orthosis Only” or “Molded to Patient Model” may not be billed w/ HCPCS codes for prefabricated base orthotics. The addition codes are considered overpayments	L2180-L2550, L2750-L2768, L2780-L2830	IOM 100-2 Ch. 15, Section 130; LCD L142; LCD Policy Article A19800	C, D

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Ambulance Services During an Inpatient Stay	Ambulance services provided during an inpatient stay should be billed to the inpatient provider, not Medicare Part B	Multiple	Medicare Benefit Policy Manual 100-02, Chapter 10, Section 10 and 10.3.3, Medicare Claims Processing Manual 100-04, Chapter 3, Sections 10.4 and 10.5 and Chapter 15, Section 10.2, Summary of Benefit and 30.1, Modifier specific to Ambulance Services	A, B, C, D
Ambulance SNF to SNF transfers	Ambulance claims for SNF to SNF transfers (modifier NN) are not separately payable under Part B.	J0000-J9999, Q0163-Q0181, 93005, 93041	CMS Pub 100-04, Chapter 15 § 30.2.2; and Change Request 3212	C, D
Anesthesia Care Package and Unbundling E&M Services	Anesthesia CPT codes 00100-01999 include E&M services billed during the anesthesia period and are only reportable if unrelated to the anesthesia procedure	00100-01999	CMS Pub 100-04, Ch. 12, section 50, NCCI Coding Policy Manual for Medicare Services	A, D
Arformoterol (Brovana) J7605	Billing should be limited to 2 vials (15 micrograms) per day	J7605	Region A/B DME PSC Bulletin August 2007, NHIC DME News April 17, 2008	C
Barium Swallow Studies Unit Billed	Billing should be limited to 1 unit per date of service	70370, 70371, 74230	LCD Policy L26594, NCCI Hospital Outpatient Services MUE Tables	C
Basic Radiation Dosimetry Calculation – Outpatient & Professional	Medical records and the claim will be reviewed to compare units reported	77300	Coding Guidelines for L30316 and RAD-014– Radiation Oncology Including Intensity Modulated Radiation Therapy (IMRT); CMS Publication 100-04, Medicare Claims Processing Manual; Chapter 13, Section 70, 70.5; CMS Physician Fee Schedule 2007, 2008, 2009, 2010	B

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Bevacizumab – Dose v. Units Billed	Should be billed one unit for every 10 milligrams per patient	J9035	MLN Matters MM5718 and MM6323, CMS Transmittals R1669CP and R1336CP	C
Blood transfusions	Billing should be limited to 1 unit per date of service	36430-36460	Federal Register, Volume 67, No.212, page 2. Program Memorandum Intermediaries, Transmittal A-01-50, April 12, 2001, page 1 CMS Pub 100-04, Ch. 4, § 231.8	A, B, C, D
Breast prosthetics	Medicare only allows one breast prosthetic per side for the useful life of the prosthesis. Medicare will cover the replacement of a breast prosthesis at any time if it is lost or is irreparable damaged.	19340,19342, A4280, L8000-L8002, L8010, L8015, L8020, L8030-L8032, L8035, L8039	IOM 100-2 Chapter 15 Section 120 LCD L11569 External Breast Prosthesis	D
Bronchoscopy	Billing should be limited to 1 unit per date of service	31622-31656	Federal Register, Volume 67, No. 251, page 8. American Medical Association (AMA), Current Procedural Terminology (CPT) American Thoracic Society Coding 2005 Update	A, B, C, D
Budesonide – Dose vs. Billed Units	Billing should be limited to one unit of service for each vial dispensed regardless of vial dose for a maximum of 62 units per month	J7626	PSC Trust Solutions News October 22, 2007, NHIC DME MAC News December 4, 2008, Policy Article A24942	B, C
Carboplatin – Dose v. Units Billed	Should be billed one unit for every 50 mg per patient	J9045	MLN Matters MM6323 and MM5718, CMS Transmittal R1669CP	C
Cataract Removal – Excess Units	Removal can only occur once per eye per the same date of service.	66830-66984	Internet Only Manual 100-08 (Program Integrity Manual), Chapter 3, Subsection 3.6; NCCI Policy Manual for Medicare Services, version 15.3. Chapter 8, Section D, #3;	A, C

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Cetuximab – Dose vs. Units Billed	Should be billed at 1 unit for every 30 mg per patient, per date of service	J9055	http://packageinserts.bms.com/pi/pi_erbitux.pdf http://www.destinationaccess.com/index.aspx?bmscontentpg=erbitux-faqs-Medicare CMS Pub 100-04; Ch. 17, § 20.1-20.5.9 MLN Matters, Number MM5718	C
Chemotherapy Administration Codes	When a CPT code reflective of chemotherapy administration is billed, the claim is required to include the code for the corresponding medication administered on the same date to the same patient.	96401-96450	http://www1.cms.gov/transmittals/downloads/r147cp.pdf ; https://www.noridianmedicare.com/p-medb/fees/medicare_participation_cd/docs/bulletins/247_med_b_news_final_29311515-3_.pdf	C
Clinical Social Worker (CSW) Services	CSW services rendered during an inpatient hospital stay are included in the facility's PPS payment and are not separately payable.	G0155, G0409	Medicare Benefit Policy Manual: Pub 100-02, Ch 15, § 170, CMS Med Learn Matters Article # SE0439	A, B, C, D
Co-Surgery not billed with modifier 62	Improper payments occur if one co-surgeon reports modifier 62 and the other does not	Multiple	CMS Pub 100-02 Chapter 12, § 40.8	C, D
CPM device after three weeks DME	CPM coverage is limited to a 3 week period following a total knee replacement	E0935	CMS Pub. 100-3 (National Coverage Determinations Manual), Chapter 1, Section 280.1 CMS Pub. 100-4 (Claims Processing Manual) Chapter 20 Section 30.2.1	D
Darbepoetin alfa (ESRD) – Dose v. Units Billed	Should be billed one unit for every 1mcg per patient	J0882	Transmittals R1669CP and R1336CP, MLN Matters MM5718 and MM6323,	C
Darbepoetin alfa (non-ESRD) – Dose v. Units Billed	Should be billed one unit for every 1mcg per patient	J0881	Transmittals R1669CP and R1336CP, MLN Matters MM5718 and MM6323,	C

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Date of Death	Medicare does not pay for services or equipment after the beneficiary's date of death.	All codes	IOM Publication 100-01 Chapter 2 Section 40.5, IOM Publication 100-4 Chapter 20 Section 30.5.4, IOM Publication 100-02, Chapter 15 , Section 110.1, OIG Report March 2000 – OEI-03-99-00200, Change Request 1190.	A, B, C, D
Destruction of Internal Hemorrhoids w/in a 90 Day Global Surgery Period	Subsequent procedures for destruction of internal hemorrhoids by thermal energy are reported and treated as a single unit for purposes of coding, billing, and reimbursement during a 90-day global surgery period.	46930	CMS Pub 100-04 Medicare Claims Processing Manual, ch12.40-40.5 Surgeons and Global Surgeries; CMS Pub 100-04 Medicare Claims Processing Manual Financial Liability Protection ch30, 30.2.1; CMS Physician Fee Schedule Search; CMS Coverage Database Palmetto GBA Article for Infrared Coagulation of Hemorrhoids A42719; Palmetto GBA - Ohio Part B Carrier	B
DME Duplicates	Medicare does not pay for duplicate services or equipment	All codes	Medicare Financial Management Manual: CMS Publication 100-06, Chapter 3, § 10.2 and § 90.1	A, C, D
DME – Group – 2 Pressure Reducing Support Surfaces	Group 2 pressure reducing support surfaces are only covered if the patient meets the characteristics specified in LCD 27009. Documentation will be reviewed for HCPCS E0277. If E0277 is inappropriate, a group 1 or 3 may be covered.	E0193, E0277, E0371-E0373, E1399	NGS LCD L27009 for Pressure Reducing Support Surfaces – Group-2 Effective 10/1/1993, Revised 4/1/2010 CMS, IOM, Publication 100-3, National Coverage Determinations Manual, Chapter 1, Part 4, Section 280.1, Durable Medical Equipment Reference List Issued: 06-03-05; Effective: 05-05-05, Implementation 07-05-05 (Alternating Pressure Pads, Mattresses and Lambs Wool Pads) National Government Services Widespread Prepayment Probe for Pressure Reducing Support Surfaces HCPCS E0277, last modified on 11/22/10	B

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DME Home Glucose Testing Supplies	The quantity of test strips and lancets that are covered depends on the usual medical needs of the diabetic patient. A4253 – 2 units of service (100 strips) in a 90-day period and A4259 – 1 unit of service (100 lancets) in a 90-day period.	A4253 and A4259	NGS LCD L27231 Glucose Monitors Original Effective Date 10/1/1993, Revised 10/1/2008 CMS IOM Publication 100-2, Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services, Section 110, Durable Medical Equipment – General OIG report A-09-08-00043, August 2010 – Review of Medicare Claims for Home Blood Glucose Test Strips and Lancets, DME MAC for Jurisdiction A	B
DME – Water Circulating Heat Pad with Pump	There is little medical evidence to support the use of water circulating heat pads. In addition, E0217 should not be used to bill for a water circulating cold pad with pump (E0218). E0218 will be denied as not medically necessary.	E0217, E0236, E0249, E1399, E0218	NGS Local Coverage Determination (LCD) L27213, Cold Therapy, Original Determination Date 4/1/1997, Revised 7/1/2007 CMS IOM Publication 100-2, Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services, §110 and 110.1, Definition of Durable Medical Equipment, Paragraph C, Necessary and Reasonable, Revised 10/1/03	B
DME while in Hospice	Separately billing for DME services related to a hospice terminal diagnosis during a hospice period are not paid separately and are included in the hospice payment	Multiple	42 CFR 418.202f, Medicare Claims Processing Manual – Pub. 100-04, Ch. 11, section 10, 30.3, 40.2, 50; Ch. 20, section 10.2; Medicare Benefit Policy Manual, Pub 100-02, Ch.9, Section 10	B, C, D
DMEPOS Provided During a Covered Part A Inpatient Hospital Stay	DMEPOS provided during an inpatient stay is not covered separately by Medicare.	Multiple	Medicare Claims Processing Manual: CMS Pub 100-04; Chapter 20 §01-210	B, C, D
Docetaxel – Dose v. Units	Should be billed one unit for every 20 mg per patient	J9170 Effective 1/1/11 J9171	MLN Matters MM6323 and MM5718, CMS Transmittal R1669CP	C

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<p>DMEPOS – Delivered to an Inpatient for Subsequent Use in the Patient’s Home</p>	<p>DMEPOS may be delivered to an inpatient for the purpose of fitting or training no more than 2 days prior to their anticipated discharge date. The DOS used on the claim form should be the date of discharge, No billing is allowed for the training or fitting in the hospital or nursing facility.</p>	<p>B4034-B9999; E0100-E9999; K0001-K0899</p>	<p>CMS Internet-Only Manuals (IOMs), Publication 100-02, Chapter 15, Section 50. 110.1 and 120; CMS Publication 100-03, Chapter 1, Part 1, Section 40.2; Publication 100-03, Chapter 1, Part 3, Section 180.2; Publication 100-03, Chapter 1. Part 4, Sections 240.2, 240, 4, 280.1, 280.2, 280.3, 280.6 and 280.7; Publication 100-04, Chapter 20-Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), Sections 10.2, 30.6, 100.2.2 and 110.3.; Publication 100-08, Chapter 4. Section 4.26.2.; Publication 100-08, Chapter 5. Section 5.2.3</p>	<p>A</p>
<p>Dolasetron – Dose v. Units</p>	<p>Should be billed one unit for every 10 mg per patient</p>	<p>J1260</p>	<p>MLN Matters MM5718, http://www.cms.gov/manuals/downloads/clm104c17.pdf f https://www.sanofi-aventisoncology.com/wps/portal/oncology/home http://products.sanofi-aventis.us/Anzemet_Injecton/anzemetinj.pdf</p>	<p>C</p>
<p>E&M Services coded with Allergy Services</p>	<p>Automated review of E/M services billed with allergy services on the same DOS without modifier 25.</p>	<p>95004-95075, 95115-95199</p>	<p>NCCI Policy Manual for Medicare Services, Versions 12.3 and higher, Ch 11, Sec J.3 (version 12.3 only) and Section K.3 (versions 13.3 and higher; CMS Publication 100-04, Ch 12 Section 200, Subsection C, revision 504, issued 3/11/2005. Please see Appendix F.; MAC Part B - J13 - LCD L28451 Allergy Immunotherapy, effective 1/1/2009 (Replaced LCD L28138) for New York and Connecticut. Please see appendix G.; MAC Part B - J13 - Article A47997 (Supplemental to LCD L28451), effective 1/1/2009 (Replaced Article A47570) for New York and Connecticut. Please see appendix H.</p>	<p>A, C</p>

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E&M Services coded with Pulmonary Diagnostic Procedures	E&M codes should not be reported for obtaining a limited history and/or performing a physical exam if related to pulmonary function testing.	99211-99212, 94010-94799	National Correct Coding Initiative Policy Manual, v13.3; v14.3; v15.3; v16.3; Chapter 11, § J.2: http://www.cms.gov/NationalCorrectCodInitEd/01_overview.asp	A, C
ECGs with Cardiac Catheterization Procedures	In most cases, separately billing of ECGs performed on the same DOS as cardiac catheterization procedures is not appropriate. ECGs unrelated to the cardiac catheterization should be billed with modifier 59	93040-93042	National Correct Coding Initiative Policy Manual, v16.3; Chapter 11, § I.3, 12, 13, 14 http://www.cms.gov/NationalCorrectCodInitEd/01_overview.asp	A
ESRD Home-Based Patients Monthly Capitation Payment (MCP) if they Receive Dialysis as an Outpatient or in a Dialysis Center	If a home-based patient receives dialysis as an outpatient or at a dialysis center in the same month the MCP physician or practitioner is paid the management fee for the home dialysis and cannot bill the MCP service codes for managing center based patients.	90951-90962, 90963-90966	Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 8, § 140; §140.1; §140.1.1, 140.1.2 and §140.4;	D
ESRD Patients Receiving 4 or More Visits/Mo have a Monthly Capitation Payment (MCP) – Outpatient and home patients	An MCP will be paid to physicians for most dialysis-related physician services furnished to Medicare ESRD patients. Only one payment is received per month and it is based on the age of the beneficiary and number of visits furnished during a calendar month.	90951-90962, 90963-90966,	Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 8, § 140; §140.1 and §140.4; American Medical Association (AMA), Current Procedural Terminology 2009, 2010	D

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Extracorporeal Photopheresis (carrier and outpatient)	May not be billed w/o diagnosis codes 202.10 to 202.18, 202.20 to 202.28, or 996.83 and 996.85	36522	https://www.cms.gov/MLN/MattersArticles/downloads/MM5464.pdf ; Medicare NCD Manual, Ch 1, § 110.4; CMS Pub 100-04; Ch. 32, § 190	C
Facility vs. Non-Facility Reimbursement (Inpatient) (site of service)	Certain professional services are reimbursed at higher rate when performed in the provider's office rather than the hospital. Claims will be reviewed to determine if the appropriate site of service was reported.	Multiple	CMS Pub 100-04; Ch. 1, § 120 CMS Pub 100-04; Ch. 12, § 20.2 CMS Pub 100-04; Ch. 13, § 20.1 - 20.2.3 CMS Pub 100-04; Ch. 16, § 80.2.1	D
Facet Joint Injections without Fluoroscopic Guidance	A review of documentation, coding, and medical necessity will be performed on claims with DOS 10/1/2007-12/31/2009 to confirm billed services are appropriately documented and supported.	64470, 64472, 64475, 64476 (Codes deleted 2010) 77003, 77012, 77021, 76942	OIG Report: Medicare Payments for Facet Joint Injection Services, Dated September 2008, report OEI-05-07-00200;	B
Filgrastim	Dose v Units billed	J1441	MLN Matters MM5718, http://www.cms.gov/manuals/downloads/clm104c17.pdf , http://www.neupogen.com/pdf/Neupogen_PI.pdf	C
Filgrastim (300 mcg)	Dose v Units Billed 1 unit equals 300 micrograms (mcg) and should be billed 1 unit for every 300 mcg per patient, per date of service	J1440	MLN Matters MM5718, http://www.cms.gov/manuals/downloads/clm104c17.pdf , http://www.neupogen.com/pdf/Neupogen_PI.pdf	C
Formoterol fumerate (perforomist) Q4099	Billing should be limited to 2 vials of formoterol (20 micrograms each) per day	Q4099 Effective 1/1/10 J7606	Cigna Government Services News April 14, 2008, Noridian DME News April 2008, NHIC DME News April 17, 2008, DME MAC Jurisdiction C Drug Fees...2 nd , 3 rd and 4 th quarters	C

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Fulvestrant – Dose v. Units Billed	Each 25mg of a dose must be billed with one HCPCS unit per patient, per date of service.	J9395	http://www1.astrazeneca-us.com/pi/faslodex.pdf CMS Pub 100-04; Ch. 17, § 20.1-20.5.9 MLN Matters, Number MM5718	C
Gastrointestinal Disorders Billed as an Inpatient Stay	These claims are identified for medical record review based on risk of improper payment for inpatient care when outpatient care was provided.	Multiple	CMS Publication 100-02 Chapter 1 § 10, Chapter 6 § 10 CMS Publication 100-08 Medicare Program Integrity Manual: Chapter 6 § 6.5.2, Chapter 13 § 13.1; 13.1.1, Chapter 13 § 13.1.3	D
Global vs. TC/PC	Global claims will be reviewed to determine if either modifier 26 or TC should have been applied to the claim.	Multiple	CMS Pub 100-04; Ch. 1, § 120 CMS Pub 100-04; Ch. 12, § 20.2 CMS Pub 100-04; Ch. 13, § 20.1 - 20.2.3 CMS Pub 100-04; Ch. 16, § 80.2.1	A, D
Global Days	E/M services performed within the surgical global days are included in payment for the surgery unless the E/M visit is unrelated to the procedure	Multiple	Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 40	A, B, C, D
Headrest with a Power Operated Vehicle or Power Wheelchair with a Captain's Chair Seat	Headrests are not separately billable when provided on the same date of service as a power operated vehicle or power wheelchair with a captain's chair seat.	E0955 billed in addition to a power operated vehicle or power wheelchair.	LCD Policy L15845	A

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<p>Heparin: Hep-Lock, Hep-Flush vs. Therapeutic Infusion of Heparin</p>	<p>Heparin, up to 10 units (Hep-Lock, Hep-Flush) (J1642) being billed when a therapeutic infusion of Heparin was administered (heparin, up to 1000 units) (J1644)</p>	<p>J1642, J1644</p>	<p>2010 Table of Drugs at link: http://www.cms.gov/HCPCSReleaseCodeSets/Downloads/DRUG2010.pdf</p>	<p>C</p>
<p>Hospice Related Services unbundled to Part B</p>	<p>Part B services related to a hospice period are bundled into the hospice payment and not separately reported.</p>	<p>Multiple</p>	<p>CMS Pub. 100-04, Ch.11, section 10, 40.2 and 50; CMS Pub 100-02, Ch. 9, Section 10</p>	<p>C, D</p>
<p>Hospital to Hospital Transfer</p>	<p>Identified MS-DRG inpatient claims improperly reported as discharge to home rather than another hospital resulting in an overpayment to the transferring hospital.</p>	<p>NA</p>	<p>CMS Publication 100-04, Ch 3, Sec 20.1.2.4, & 40.2.4; CMS Publication 100-04, Ch 25, Sec 75.2, FL-17, & FL 18; CMS CR 2934, Dated February 6, 2004; CMS CR 2716, Dated August 1, 2003; CMS CR 2891, Dated August 22, 2003; CMS CRs 2716 and 2891, Dated January 23, 2004); CMS CR 3389, Dated July 30, 2004; Federal Register, 42 CFR 412.4; Federal Register, August 22, 2007, Changes to the Hospital IPPS and Fiscal Year 2008 Rates: Final Rule; Federal Register, October 10, 2007, Changes to the Hospital IPPS and Fiscal Year 2008 Rates Correction: Final Rule; Federal Register, August 19, 2008, Changes to the Hospital IPPS and Fiscal Year 2009 Rates Correction: Final Rule</p>	<p>A, B, C</p>

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Incorrect Bilateral Billing for Codes with Bilateral Indicator 3	Billing for CPT codes that describe bilateral services with bilateral indicator 3 (bilateral service) with modifier 50 is improper and will result in an overpayment.	Multiple	Highmark Medicare Services, Medicare A/B Reference Manual, Ch 22, sec 22.1.e.1. CMS Publication 100-04 Ch12, Sec 40.7, Subsection B and C. See Appendix F.	A
Incorrect Patient Status – Acute	Incorrect billing of discharge status when patient is transferred to another facility	Multiple	CMS Publication 100-04, Ch 3, Sec 40.2.4 and MedLearn Matters SE0801, SE0459, MM2934 and MM3829	D
Incorrect Patient Status – IRF	Incorrect billing of discharge status when patient is transferred to another facility	Multiple	CMS Publication 100-04, Ch 3 §140.2.3, CR 5354, Transmittal R1099CP, OIG Report "Nationwide Review of Inpatient Rehabilitation Facilities' Compliance with Medicare's Transfer Regulation (A-04-04-00008 dated September 2006 and MedLearn Matters SE0801 and SE0459	D
Incorrect Use of Modifier 51 with CPT Code 51797	Underpayments associated with billing CPT code 51797 with modifier 51. CPT code 51797 is an add – on code with multiple procedure indicator of 0, therefore, not subject to a payment reduction.	51797	CMS National Physician Fee Schedule Relative Value File Calendar Year for 2008, 2009 and 2010; CMS Transmittal R1528CP, CR 6087, effective May 30, 2008, changes retroactive to January 1, 2008; CMS Publication 100-04 Ch 12 sec 40.6.C;	A
Infliximab (Remicade) Billed w/ Therapeutic Injection/Infusion	Should be billed as chemotherapy and other highly complex drug or highly complex biologic agent infusion administration. Some providers will bill w/ therapeutic infusion administration.	J1745	LCD for Infliximab (Remicade) Cahaba L30030 LCD for Infliximab (Remicade) Pinnacle L19818 LCD for Infliximab (Remicade) WPS L26658 LCD for Infliximab (Remicade) First Coast L29198, L29440	C

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Infusion Pumps, Accessories & Drugs	Pump accessories and infused drugs are not payable when the pump is denied	Multiple	CMS Publication 100-3, Chapter 1, § 280.14, LCD L11570 Policy External Infusion Pumps	D
Initial Hydration, Infusion and Chemotherapy Administration	When administering multiple infusions, injections or combinations, the physician should report one "initial" service code unless protocol requires two separate IV sites	2009-2011: 96360-96425 2008: 90760-90779, 96401-96425	Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 30.5 (e)	C, D
Initial/Preparatory Knee Disarticulation Prosthesis	Prosthetic substitutions and/or additions billed in conjunction with the initial prosthesis	Multiple	LCD L11464	A
Inpatient Admissions without a Physician's Inpatient Admit Order	All admissions must have an order to qualify and be paid as an inpatient stay	NA	42 CFR Part 482.24, MBPM Ch.1 Section 10; MCPM Ch.3 Section 10 and 40.2.2	A, B, C, D
Intravenous Immune Globulin (IVIG) is billed with chemotherapy and highly complex drug infusion administration (OP – Hospitals and Physicians)	IVIG infusion administration should be billed using therapeutic infusion administration codes along with the appropriate J-code for the IVIG drug	2009-2011: 96365-96379 and C9270, J0850, J1459, J1561, J1566, J1568, J1569, J1572, J1599 2008: 90765-90779	LCD for IVIG – Cahaba L30029; LCD for IVIG – Pinnacle L31097; LCD for IVIG – Palmetto L28275; LCD for IVIG – Trailblazer L26774; http://www.gammagardliquid.com/order-gammagard-liquid/suggested-coding.htm	C
Irinotecan – Dose v. Units Billed	Should be billed one unit for every 20 mg per patient	J9206	MLN Matters MM5718 and MM6323, CMS Transmittals R1669 CP and R1336CP	C
IV Hydration	Initial hydration should be billed with maximum number of units (1) per patient, per date of service	2009-2011: 96360 2007-2008: 90760	CMS Pub 100-4 Ch 12, Section 30.5; CMS Pub100-20, Transmittal 419, page 7. MLN Matters, MM6349 R/T CR Release Date 12.19.08, page 4	A, B, C

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Kidney and UTI Disorders billed as an inpatient stay	These claims are identified for medical record review based on risk of improper payment for inpatient care when outpatient care was provided.	NA	CMS Publication 100-02 Medicare Claims Processing Manual: Chapter 1 § 10, Chapter 6 § 10 CMS Publication 100-08 Medicare Program Integrity Manual: Chapter 6 § 6.5.2, Chapter 13 § 13.1; 13.1.1, Chapter 13 § 13.1.3	D
Knee Orthotics	Separately billing for orthotic codes that should be bundled into the base orthotic code.	Multiple	LCD Policy L27058 Knee Orthoses, LCD Policy Article A47178 Knee Orthosis, MBPM Ch.15, section 120, Policy Article A47174	B, D
Left-sided Cardiac Catheterization – Outpatient	Should only be billed once per patient per date of service. (Excluding claims with modifiers 73 and 52)	93462 Prior to 2011 93524	RAC did not cite any references.	C
Left-sided Cardiac Catheterization – Physician (Carrier)	Should only be billed once per patient per date of service. (Excluding claims with modifiers 73 and 52 and 26)	93462 Prior to 2011 93524	RAC did not cite any references.	C
Leuprolide Acetate (for depot suspension) – Dose v. units	Each HCPCS unit of leuprolide represents 7.5mg. A 7.5 mg injection (1 mo formulation) must be billed with 1 unit per patient per date of service, a 22.5 mg injection (3 mo formulation) must be billed with 3 units per patient per date of service, 30 mg. injection (4 month formulation) must be billed with 4 units per patient per date of service and a 45 mg. injection (6 month formulation) must be billed with 6 units per patient per date of service.	J9217	http://pitap.abbott.com http://products.sanofi-aventis.us MCPM Ch.17, MLN Matters MM5718	C

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Lower Limb Prosthetics – Complex Review	Documentation of patient rehabilitation potential must match the lower limb prosthetic as billed.	Multiple	Section 1861(s) (9) of the Act. CMS IOM, Publication 100-2 Benefits Policy Manual, Chapter 15 Section 130. LCD L11453 Lower Limb Prosthetics CMS IOM, Publication 100-02 Benefits Policy Manual, Chapter 15, §20.3	C, D
Lower Limb Suction Value Prosthesis	HCPCS codes reflecting prosthetic lower limb additions with suction sockets include the addition of locking mechanisms and those services should not be reported in addition to the lower limb additions with suction sockets on the same date of service.	L5647, L5671, L5652	LCD Policy Article A25310, Region A DMERC PSC Bulletin; LCD L11442	A, C
Manual Wheelchair Accessories Billed with Power Wheelchair Bases	Manual wheelchair options and accessories must be supplied for manual wheelchairs and power options and accessories must be supplied for power wheelchairs	Multiple	LCD L11473	A
Medical Supplies and Home Health Consolidated Billing	Under Home Health PPS, the PPS rate includes all nursing and therapy services, routine and non-routine medical supplies and home health aide and medical social services. DME is excluded from consolidated billing.	Multiple	MCPM 100-4, Ch. 10, section 20 and section 140.2, Overview on Home Health Consolidated Billing	C, D

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Medically Unlikely Edit List	Errors made in billing where more units were billed for a patient than what is medically likely. Part A Outpatient, Part B, DME	Multiple	NCCI MUE edits, Cahaba GBA Medicare B Newslines July 2007, pg 37, CMS Claim Review Programs: MR, NCCI Edits, MUEs, CERT, RAC; MLN Matters Number MM5402 Medical Unlikely Edits	A, B, C, D
Mobility DME Paid After Claim Patient Lift Paid	When coverage is provided for the Multi-Positional Patient Transfer System, payment will be discontinued for any other mobility assistive equipment.	E0630, E0635, E0639, E0640, E0636, E1035, E1036	LCD for Patient Lifts L5064	C
Mohs Surgery Pathology Billed by Separate Provider	If the preparation & interpretation of the slides of tissue taken during a Mohs surgery are performed by someone other than the surgeon or his or her employee, then CPT codes 17311-17315 should not be reported since they include both the excision & the pathology services.	17311-17315, 88300-88309, 88331, 88332, 88342	LCD # L28278 Effective with Dates of Services Performed on or after 09/02/2008 for Hawaii, California and Nevada. LCD # L24331 Effective with Dates of Services Performed on or after 12/01/2006 for Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming.	D
MRI Services to Outpatients with a History of Cardiac Pacemaker	MRIs are not covered services for beneficiaries with a history of cardiac pacemaker on or after February 24, 2011 unless in a clinical study approved by Medicare	Multiple	National Coverage Determination (NCD) for Magnetic Resonance Imaging (220.2)	D
Multiple DME Rentals within a Month	Pertains globally to DME bundling for services provided on the same date of service.	Multiple	CMS Pub 100-04, Ch 20, §30.1, 30.2, 30.5, 30.7, 130.8, Social Security Act, Volume I, Title XVIII, Section 1834	A, B

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Multiple Surgery	An automated review is in place to identify surgical claims with a multiple procedure indicator value of "2" or "3" reported by the same physician, on the same patient, on the same day, whether on different claims, different lines, or with a number greater than 1 in the units column for each code reported on the claim form.	Multiple	CMS Pub 100-04 Chapter 12; CMS Pub 100-04 Chapter 23; WPS – Wisconsin Physicians Services; Palmetto GBA	B
Multiple Surgery Reduction Errors: Single Line Modifier 51 Underpayments and Overpayments	If modifier 51 is appended to a procedure code but there is no other procedures, the reimbursement is inappropriately reduced by 50%	Multiple	Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 40.6; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 23, § 30	C, D
NCCI Edits	Overpayments may be identified under the same claim number or different claim number when services are inappropriately unbundled.	Multiple	NCCI Policy Manual for Medicare Services; CMS, Pub. 100-04, Ch.23, section 20.9; Ch.12 section 30	A, D
NCCI – OPPS	Column II code will be denied if billed by the same provider and same date of service as a Column I code. (Mutually Exclusive and Non-Mutually Exclusive)	Multiple	Internet Only Manual 100-04 Medicare Claims Processing Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), Subsection 20.9 (Correct Coding Initiative), revision effective 10/1/2003; Column I/Column II code pairs are date sensitive. 2) Integrated Outpatient Code Editor Software, versions 8.3 (effective 10/1/2007) and higher, edit #s 19, 20, 39, and 40.; NCCI Edits - Hospital Outpatient PPS; Outpatient Code Editor - Overview;	A

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NCCI – Part B for Ambulatory Surgical Centers	Column II code will be denied if billed by the same provider and same date of service as a Column I code. (Mutually Exclusive and Non-Mutually Exclusive)	Multiple	Internet Only Manual 100-04 Medicare Claims Processing Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), Subsection 20.9 (Correct Coding Initiative), revision effective 10/1/2003; Internet Only Manual 100-4 Medicare Claims Processing Manual, Chapter 14 (Ambulatory Surgical Centers), Subsection 20.9 (Rebundling of CPT codes); revision effective 10/1/2003. Column I/Column II code pairs are date sensitive.;	A
NCCI – Part B for Physician (Carrier)	Column II code will be denied if billed by the same provider and same date of service as a Column I code. (Mutually Exclusive and Non-Mutually Exclusive)	Multiple	Internet Only Manual 100-04 Medicare Claims Processing Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), Subsection 20.9 (Correct Coding Initiative), revision effective 10/1/2003	A, C
Nebulizer, Demonstration and Evaluation Units Billed	Billing should be limited to 1 unit per date of service	94664	Federal Register 42 CFR Part 405 , Vol. 70, No. 223, November 21, 2005, Cahaba Medicare A Newline Vol.14, No. 6, March 1, 2007	C
Nervous System Disorders Billed as an Inpatient Stay	These claims are identified for medical record review based on risk of improper payment for inpatient care when outpatient care was provided.	NA	CMS Publication 100-02 Medicare Claims Processing Manual: Chapter 1 § 10, Chapter 6 § 10 CMS Publication 100-08 Medicare Program Integrity Manual: Chapter 6 § 6.5.2, Chapter 13 § 13.1; 13.1.1, Chapter 13 § 13.1.3	D
Neulasta (Pegfilgrastim)	Billing should be limited to 1 unit per 6mg rather than 1 unit per each mg administered	J2505	CMS Manual System, Publication 100-04 Medicare Processing Manual, Transmittal 949 (dated May 12, 2006) MLN Matters Number MM55912, Release Date, January 18, 2008 HCPCS Level II 2007, 2008, 2009	A, B, C, D

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Newborn Pediatric age limits	Certain codes should not be billed for patients exceeding age limits published by CPT	Multiple	AMA CPT	A, C, D
Not a New Patient	New patient CPT codes are only payable if the patient has not received any professional services from the physician or physician group within the previous 3 years	99201-99205	Medicare Claims Processing Manual Pub 100-04, Ch. 12, Section 30.6.7	A, C, D
Once in a lifetime procedures	Certain procedures should only be performed once in a person's lifetime	Multiple	CMS Pub 100-08, Ch.3, § 3.6	A, B, C, D
OP Services Within 72 hrs of Admit. Part A Outpatient	Certain services provided three days prior to admit are included in inpatient payment	Multiple	CMS Claims Processing Manual 100-04, Chapter 3 §40.3, CMS Claims Processing Manual 100-04, Chapter 3 §10.4 and Benefit Policy Manual 100- 02, Chapter 6 §10	D
Outpatient Claims Billed w/in a PPS Inpatient Admission	Reimbursement of outpatient services w/in a PPS Hospital stay is considered a duplicate payment.	Multiple	CMS Claims Processing Manual 100-04, Chapter 1 §120; CMS Claims Processing Manual 100-04, Chapter 3 §40.3.1; CMS Claims Processing Manual 100-04, Chapter 18 §10	B

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Oxaliplatin	Should be billed 1 unit every 0.5mg administered per patient per DOS	J9263	Federal Register/Vol.70, No.217/Thursday, November 10, 2005/Rules and Regulations Health and Human Services: Medicare Program Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2006 Payment Rates; Final Rule. CMS Transmittal 786, Change Request 4250; CMS Transmittal 786, Change Request 4250; CMS Transmittal A-03-051, Change Request 2771; CMS National Coverage Determinations Manual, 110.7 ; CMS Pub 100-03 Medicare National Coverage Determinations, Transmittal 38; MLN Matters MM3742, June 15, 2005; The clinical trials identified by CMS; CMS Pub 100-04 Chapter 20.4 Reporting of Service Units; CMS Benefit Policy Manual Chapter 15, 50.4.5. CMS Pub 100-04 Claims Processing Manual Transmittal 588; The Office of Inspector General (OIG), August, 2009 (A-05-09-0052); The Office of Inspector General (OIG), July, 2009 (A-04-09-06100); Centers for Medicare & Medicaid Services, Hospital Outpatient PPS, April 2008, Addendum B: Line 12255	B
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Oxygen Accessories	No separate payment for accessories billed in conjunction with an oxygen system rental in the prior to the date of service or subsequent month. These supplies are included in the rental allowance.	Multiple	LCD L11468; LCD Policy Article A33768	A
Paclitaxel protein-bound particles – Dose v. Units	Should be billed one unit for every 1mg per patient, per date of service.	J9265	MLN Matters MM5718, MCPM Ch.17, www.abraxane.com	C
Paclitaxel – Dose v. Units	Should be billed one unit for every 30mg per patient, per date of service.	J9265	MLN Matters MM5718, MCPM Ch.17, http://packageinserts.bms.com http://www.bdipharma.com	C
Palonosetron – Dose vs. Units Billed	Billed one unit for every 25mcg administered per patient	J2469	http://www.aloxi.com/Common/downloads/PI-FINAL.pdf CMS Pub 100-04; Ch. 17, § 20.1-20.5.9 MLN Matters, Number MM5718	C
Pamidronate Disodium – Dose v. Units	Should be billed one unit per 30 mg per patient	J2430	MLN Matters MM5718; MCPM Ch.17, http://dailymed.nlm.nih.gov	C
Parenteral Enteral Nutrition (PEN) Supplies	Billing should be billed with maximum number of units (1) per patient, per date of service	Multiple	CMS Pub. 100-3 (National Coverage Determinations Manual), Chapter 1, Section 180.2. LCD Policy L11576 Parenteral Nutrition, LCD Policy L11568 Enteral Nutrition, LCD Policy Article A37077 Parenteral Nutrition	D
Parenteral Nutrition Additive with Premix Solutions	Premix parenteral nutrition solutions include payment for the carbohydrates, amino acids or additives and may not be separately billed	B5000-B5200	LCD L5063; Article A37215	A

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Part B Duplicates – Automated Review	Duplicate processing of charges or claims results in improper overpayment. If more than one E/M service is provided in the same day, it must be reported as one service, unless the services were performed for unrelated problems	Multiple	IOM 100-6 Medicare Financial Management Manual Chapter. 3 § 10.2 and 90.1; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 30; Chapter 1, §120	A, B, C, D
Pharmacy Supply & Dispensing Fees	Must be reported in conjunction with an oral anti-cancer, anti-emetic, immunosuppressive drug or inhalation drug	Q0510 – Q0514, G0333.	Internet Only Manual 100-04 (Medicare Claims Processing Manual), Chapter 17 (Drugs and Biologicals), Section 80.7. Transmittal 754, Change Request 3990, Requirement 3990.15. DME MAC Jurisdiction A Article for Nebulizers A24944 (LCD L11499). DME MAC Jurisdiction A Article for Oral Anticancer Drugs A25227 (LCD L5057). DME MAC Jurisdiction A Article for Oral Antiemetic Drugs A25228 (LCD L5058). DME MAC Jurisdiction A Article for Immunosuppressive Drugs A23662 (LCD L11531).	A, C
Place of Service Errors ASC vs. Office	Place of service improper payments involving same day services in ASC and office setting	Multiple	MCPM Ch.12, section 20.4.2 http://oig.hhs.gov/oas/reports/region1/10800528.pdf	A, B
Place of Service Errors – Hospital Inpatient Setting	Place of service improper payments to physician when billing place of service codes other than hospital inpatient.	Multiple	42 CFR § 414.22(b)(5)(i)(B) Medicare Claims Processing Manual: Publication 100-04; Chapter 12, § 20.4.2 OIG Reports Medicare Claims Processing Manual: Publication 100-04; Chapter 26 § 10.5	C

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Practice Expense (PE) Relative Value Unit (RVU) Increase for CPT Code 93503	Claims for CPT code 93503 with dates of service on or after January 1, 2009 that were processed prior to the October 5, 2009 implementation date of Change Request 6617 are underpaid based on the retro-actively increased RVU.	93503	CMS Manual System, Change Request 6617; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 23	D
PreAdmission Testing	Diagnostic services provided to patients by the admitting hospital within 3 days prior to and including admission are included in the inpatient payment	Multiple	CMS Internet-Only Manual, Medicare Claims Processing Manual, Publication 100-04, Chapter 3, Inpatient Hospital Billing, Section 40.3, Outpatient Services Treated as Inpatient Services	B
Procedures performed during the Global Period of other procedures	Separate payment not allowed for procedures billed within a global period unless it is unrelated	Multiple	Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 40.2, 40.3 and 40.4; and, Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 23, Addendum - MPFSDB Record Layouts	C, D
Professional Co-Surgery Bundling	Surgery provided to a patient when the patient is a resident at a SNF are bundled into one package and billed by the SNF. If billed separately it is considered an overpayment.	Multiple	CMS Publication 100-04; Ch 12 §40.8 and Ch 23.	B

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<p>Prosthetic Addition Codes</p>	<p>Certain prosthetic substitutions and or additions of procedures and components are covered in accordance with the functional level assessment, except for certain identified codes cited which will be denied as not medically necessary.</p>	<p>Multiple</p>	<p>LCD L11442 Lower Limb Prostheses (below the knee)</p>	<p>C</p>
<p>Prosthetic Bundling, Prosthetic Additions with Initial or Preparatory Knee Prosthesis</p>	<p>Certain services are not considered reasonable and necessary when billed in addition to an initial below knee prosthesis or preparatory below knee prosthesis.</p>	<p>L5500, L5510-L5530, L5535 L5540 billed in addition to multiple codes. For example, L5629, L5638, L5620, L5645.</p>	<p>LCD Policy L11464</p>	<p>A, B, D</p>
<p>Radiologists billing E&M with Diagnostic Mammography Services</p>	<p>Radiologists should not bill E&M codes on the same DOS as diagnostic mammography services whose sole responsibility is the performance of the mammogram. A physician may bill an E&M service in addition to the mammogram if there are separately identifiable services rendered other than the components of the mammogram.</p>	<p>77055, 77056, G0204, G0206</p>	<p>National Government Services, Part B, LCD L26890</p>	<p>A</p>

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Repetitive Eye Surgery	Subsequent procedures for Destruction & prophylaxis of repetitive eye surgeries are treated as a single unit for purposes of coding, billing, and reimbursement during a 90-day global surgery period.	67141-67229	CMS Claims Processing Manual 100-04, Chapter 12 §30.6.6; http://www.wpsmedicare.com/part_b/education/modifier_58.pdf ; LCD Policy L28497	B
Rituximab – Dose v. units	Should be billed one unit for every 100mg per patient	J9310	MLN Matters MM5718, MCPM Chapter 17, www.genentechaccessolutions.com/ www.gene.com/	C
Rituximab – Non-Covered/Non-Allowed (Professional Services and Outpatient)	May only be billed with the covered ICD-9 codes that are covered in the applicable LCDs, otherwise an overpayment will occur.	J9310	NGS, Inc. LCD L25820 / A46093 / A49636 – Drugs and Biologicals, Coverage of, for Label and Off-Label Use / Article for Rituximab; CMS Publication 100-04 Ch 1 & Ch 15; Publication 100-08 Ch 13	B
SNF Consolidated Billing	Most services provided to beneficiaries during a covered Part A SNF stay are bundled into the SNF payment and should not be billed separately.	Multiple	CMS Pub 100-04; Chapter 6 § 10, 20, 80 and 110.2.2; Pub 100-04; Chapter 20 § 211	B, C, D
Solid Seat Insert	Solid seat inserts are not separately payable when provided in addition to a seat or seat back wheelchair cushion.	E0992 billed in conjunction with a seat or seat back wheelchair cushion.	LCD Policy L15845, LCD Policy Article A17918	A
Supplies for Maintenance of Drug Infusion Catheters	Billing should be limited to 1 unit per week.	A4221	CMS Pub. 100-3 (National Coverage Determinations Manual), Chapter 1, Section 280.14 LCD L11570 External Infusion Pumps	C, D

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TC of Diagnostic Procedures During Inpatient IDTF	The technical component (TC) of diagnostics is not payable to the Part B provider while the patient is in a covered Part A inpatient stay.	Multiple	Medicare Claims Processing Manual: CMS Publication 100-02; Chapter 15, § 30.1	D
TC of Lab/Pathology	The technical (TC) component of lab/path services may not be paid under Medicare Part B when furnished to patients in inpatient or outpatient hospital settings.	Multiple	CMS Pub 100-04; Chapter 16, § 80.2.1	D
TC of Radiology	The technical (TC) component of radiology services may not be paid under Medicare Part B when furnished to patients in inpatient or outpatient hospital settings.	Multiple	OIG Report A-01-04-00528; CMS Pub. 100-04, Ch. 13, Section 20.2.1; MedLearn Matters #MM537; Change request 5675	A, D
Tenecteplase – Dose v. Units	Should be billed one unit for every 50 mg per patient per date of service	J3100 Effective 1/1/09 J3101	MLN Matters MM4229 and MM5718; MCPM Ch 17; www.tnkase.com	C
Therapeutic Footwear Utilization	Limits the use of shoes and inserts to one of the following w/in 1 calendar year for diabetics: 1 pair of custom molded shoes (including inserts provided w/ shoes) and 2 additional pairs of inserts; or 1 pair of depth shoes and 3 pairs of inserts	A5501, A5512, A5513, A5500	IOM 100-2 Ch. 15, section 140; LCD L157; LCD Policy Article A37076	D
Transcutaneous Electrical Nerve Stimulators (TENS) Supplies Bundling	Medicare does not allow separate payment for TENS supplies during the rental month or the first month after purchase of a TENS unit.	E0720, E0730, E0731, A4557, A4595	LCD for Transcutaneous Electrical Nerve Stimulators (TENS) (L11495) Article for Transcutaneous Electrical Nerve Stimulators (TENS) - Policy Article - (A37074)	D

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Untimed codes	Billing should be limited to 1 unit per date of service	92506, 92597, 92611, 92612, 92614, 92616, 95833, 95834, 96110, 96111, 97001, 97002, 97003, 97004	CMS Pub 100-04, Transmittal 1019, dated 8.3.06, pages 7-11 CMS Pub 100-04, Ch. 5, § 20.2	A, B, C, D
Urological Bundling	Separately billing for options and accessories that are included in other procedure codes.	Multiple	LCD Policy L11581	A, C, D
Verteporfin & Ocular Photodynamic Therapy without Fluorescein Angiography	Verteporfin and Ocular Photodynamic Therapy (OPT) must be billed in conjunction with fluorescein angiography or indocyanine-green angiography	J3396, 67221-67225, 92235, 92240	CMS IOM 100-03, Ch1 Part 1, Section 80.2-80.3.1; CMS NCD 80.2 Ocular Photodynamic Therapy (OPT)	A
Visits to Patients in Swing Beds	If the inpatient care being billed by the hospital with swing bed approval is for nursing facility care, then the nursing facility codes apply.	Multiple	Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 30.6.9.	D
Wheel Attachment with New Non-Wheeled Walker	Wheel attachments are not reimbursable if provided on the same day or within month of the initial issue of a non-wheeled walker.	E0155 billed on the same day or within one month of a non-wheeled walker. For example, E0130, E0135, E0141, E0143)	LCD Policy L11472	A
Wheelchair bundling	Separately billing for options and accessories that are included in other procedure codes.	Multiple codes affected. For example, E0973, E2209, K0015, K0017, K0018, K0019, K0020	LCD Policy L11473, Wheelchair Options/Accessories	A, B, C, D
Zoledronic acid (Zometa and Reclast) Dose v Units Billed	Should be billed 1 unit for every 1mg per patient	J3487 & J3488	LCD J3487; Zometa package insert. Novartis Pharmaceuticals Corporation	C, D