

MEDICARE QUARTERLY PROVIDER COMPLIANCE NEWSLETTER

Guidance to Address Billing Errors

Volume 8, Issue 1



PRINT-FRIENDLY VERSION

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

INTRODUCTION

This newsletter is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Fee-For-Service (FFS) Program. It 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 newsletter is released on a quarterly basis. An [archive](#) of previously-issued newsletters, which includes keyword and provider-specific indices, is available on the Centers for Medicare & Medicaid Services’ (CMS) website.



Physicians



Non-Physician
Practitioners



Durable Medical
Equipment Suppliers

COMPREHENSIVE ERROR RATE TESTING (CERT): ARTHROSCOPIC ROTATOR CUFF REPAIR

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Provider Types Affected: Physicians

Background: The rotator cuff is a frequent location of shoulder pain which can result in weakness and shoulder instability. Arthroscopic rotator cuff repair is a procedure to repair tears of the rotator cuff.

Description of Special Study: The CERT review contractor conducted a special study of claims with lines for arthroscopic rotator cuff repair procedures billed with Healthcare Common Procedure Coding System (HCPCS) code 29827 (arthroscopy, shoulder, surgical; with rotator cuff repair) submitted from January through March 2016.

Finding: Insufficient Documentation Causes Most Improper Payments

Most improper payments for HCPCS code 29827 in this special study were due to insufficient documentation errors. Insufficient documentation means something was missing from the medical records. For example, claims with insufficient documentation lacked one or more of:

- Supporting documentation for the medical necessity of the procedure
- Procedure note
- Physician's signature, or signature attestation, on a procedure note or diagnostic report

Example of Improper Payment due to Insufficient Documentation - Missing documentation to support medical necessity

An orthopedic surgeon billed for HCPCS code 29827 and submitted the following:

- Signed operative report
- Signed pre-operative History and Physical for medical clearance prior to surgery

An additional request for documentation returned no documentation. The submitted records were missing signed clinical documentation to support medical necessity for the billed procedure. Some examples of documentation to support medical necessity may include, but are not limited to: failed conservative treatments prior to the procedure, signed and dated diagnostic imaging reports, or preoperative surgeon notes. The CERT review contractor scored this claim as an insufficient documentation error and the MAC recovered the payment from the provider.

WHAT YOU SHOULD KNOW

Most improper payments for HCPCS code 29827 in this special study were due to insufficient documentation errors. Insufficient documentation means something was missing from the medical records.

HELPFUL LINKS

[Chapter 15, Section 10](#) on Supplementary Medical Insurance (SMI) Provisions in The "Medicare Benefit Policy Manual".

Example of Improper Payment due to Insufficient Documentation - Missing documentation to support medical necessity

An orthopedic surgeon billed for HCPCS code 29827 and submitted the following:

- Signed operative report which documented left rotator cuff repair, repair of Superior Labral tear from Anterior to Posterior (SLAP) lesion, and biceps tenotomy
- Unsigned orthopedic surgeon's note which documented a fall injury with pain in the rotator cuff distribution and weakness in the arm, with tenderness and pain over the distal aspect of the biceps
- Unsigned orthopedic surgeon's note which documented left shoulder rotator cuff tear via Magnetic Resonance Imaging (MRI) with persistent weakness and failed conservative care measures
- Two unsigned orthopedic surgeon's post-operative follow-up visit notes

An additional request for documentation returned duplicate documentation. The submitted records were insufficient to support the medical necessity for the procedure because the orthopedic surgeon's clinical documentation was unsigned and a signature attestation was not submitted. Medicare requires that services provided/ordered be authenticated by the author. The provider could have completed a signature attestation to correct this error. The CERT review contractor scored this claim as an insufficient documentation error and the MAC recovered the payment from the provider.

Resources

You may want to review the following information to help avoid insufficient documentation errors:

- SSA 1833 (e) is available at https://www.ssa.gov/OP_Home/ssact/title18/1833.htm
- 42 CFR 424.5(a)(6) is available at <https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol3/pdf/CFR-2011-title42-vol3-sec424-5.pdf>
- The "Medicare Benefit Policy Manual," Chapter 15, Section 10 on Supplementary Medical Insurance (SMI) Provisions is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>
- The "Medicare Benefit Policy Manual," Chapter 15, Section 30 on Physician Services is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>
- The "Medicare Program Integrity Manual," Chapter 3, Section 3.3.2.4 on Signature Requirements is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf>
- The CERT Program website is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/index.html>
- The CERT provider website is available at <https://certprovider.admedcorp.com/>

**COMPREHENSIVE ERROR RATE TESTING (CERT): HOSPITAL
OUTPATIENT SERVICES****P****NPP**

Provider Types Affected: Physicians, Non-Physician Practitioners (NPPs), and providers who bill type of bill 12x through 19x

Background: Medicare Fee-for-Service (FFS) Part A provides coverage for some services provided in the hospital outpatient setting. Covered services include, but are not limited to, the following:

- Medication administration
- Laboratory and other diagnostic testing
- Outpatient surgical procedures
- Therapy services

Payment Methodology: The Hospital Outpatient Prospective Payment System (OPPS) pays for designated hospital outpatient services.¹ In most cases, the unit of payment under the OPPS is the Ambulatory Payment Classification (APC). The Centers for Medicare & Medicaid Service (CMS) assigns individual services (Healthcare Common Procedure Coding System [HCPCS] codes) to APCs based on similar clinical characteristics and similar costs. The payment rate and copayment calculated for an APC apply to each service within the APC. Within each APC, payment for dependent, ancillary, supportive, and adjunctive items and services is packaged into payment for the primary service. For example, packaged services under an outpatient surgical procedure APC may include: supplies, anesthesia, operating room and recovery room use, drugs and biologicals, and imaging services. Separate payments are not made for such packaged services, which are paid under the packaging of the primary service.

Payment Example: The following depicts how payment occurs for type of bill 131 for an outpatient surgical claim.

The HCPCS code 11042 (Debridement, subcutaneous tissue (includes epidermis and dermis); first 20 square centimeters or less) is billed with APC 00016 (Level III Debridement & Destruction). The final allowed charge for APC code 00016 is \$284.11. Also packaged into the APC code 00016 payment are medication and medical-surgical supplies. Both of these services have a final allowed charge of \$0.00 because they are packaged into the APC payment of the surgery, APC code 00016.

**WHAT YOU
SHOULD KNOW**

The payment rate and copayment calculated for an APC apply to each service within the APC. Within each APC, payment for dependent, ancillary, supportive, and adjunctive items and services is packaged into payment for the primary service.

HELPFUL LINKS

[Chapter 15, Section 80.6](#) on Requirements for Ordering and Following Orders for Diagnostic Tests in The “Medicare Benefit Policy Manual”.

¹Certain types of services are excluded from payment under the OPPS.

The improper payments described below are for claims paid under OPPS APCs. These claims are assessed on the APC payment line of a claim, not on a line of service that has no payment that is packaged into the APC service payment.

Finding: Insufficient Documentation Causes Most Improper Payments

For the 2016 report period, the improper payment rate for hospital outpatient services² was 5.4 percent, accounting for 7.5 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for outpatient services during the 2016 report period was \$3.1 billion. The majority of improper payments for hospital outpatient services were due to insufficient documentation errors.

Many hospital outpatient claims with insufficient documentation lacked:

- An order (or documentation supporting the intent to order laboratory or other diagnostic tests),³ and/or
- Supporting documentation for the medical necessity of the service provided.

Example of Improper Payment due to Insufficient Documentation - Missing order

A provider billed APC payment lines for HCPCS code 96365 (Intravenous infusion of therapeutic drug; initial up to 1 hour) with APC code 00439 (Level IV Drug Administration) and HCPCS code 96366 (Intravenous infusion of therapeutic drug; each additional hour) with APC code 00436 (Level I Drug Administration). The service of HCPCS code J3370 (Vancomycin injection, 500 mg) was a packaged service under APC code 00439 and APC code 00436.

The provider submitted the following:

- Unsigned order for Vancomycin
- Medication administration record
- Signed progress note demonstrating medical necessity of the Vancomycin

An additional request for documentation returned an order for peripherally inserted central catheter maintenance and duplicate documentation. The submitted records were missing the provider's authenticated order for the Vancomycin. The CERT review contractor scored this claim as an insufficient documentation error and the MAC recovered the payment from the provider.

²For improper payment reporting purposes, hospital outpatient services are all services billed with type of bill 12x through 19x (for example, OPPS, laboratory, and others).

³A "diagnostic test" includes all diagnostic x-ray tests, all diagnostic laboratory tests, and other diagnostic tests furnished to a beneficiary. While an order for a diagnostic test is not required to be signed, the ordering provider must clearly document, in the medical record, his or her intent that the test be performed. See the "Medicare Benefit Policy Manual," Chapter 15, Section 80.6 on Requirements for Ordering and Following Orders for Diagnostic Tests.

Example of Improper Payments due to Insufficient Documentation - Missing documentation to support medical necessity

A provider billed an APC payment line for HCPCS code 77080 (Dual-energy X-ray absorptiometry [DXA]) with APC code 00261 (Level II Plain Film Including Bone Density Measurement).

The provider submitted the following:

- Signed order for bone density study
- Signed bone density study results

Additional requests for documentation to both the billing and ordering provider returned duplicate documentation. The submitted records were missing documentation to support the medical necessity of the service billed. The CERT review contractor scored this claim as an insufficient documentation error and the MAC recovered the payment from the billing provider.

Example of Improper Payments due to Insufficient Documentation - Missing order (or intent to order) & Missing documentation to support medical necessity

A provider billed an APC payment line for HCPCS code G0463 (Hospital outpatient clinic visit for assessment and management of patient) with APC code 00634 (Hospital Clinic Visits). The service of HCPCS code 85610 (Prothrombin time) was a packaged service under APC code 00634.

The provider submitted the following:

- Prothrombin time results for the date of service
- Signed pharmacist progress note



Additional requests for documentation to both the billing and ordering provider returned no documentation. The submitted records were missing the provider's order, or documentation supporting the intent to order, and documentation supporting the medical necessity of the service billed. The CERT review contractor scored this claim as an insufficient documentation error and the MAC recovered the payment from the billing provider.

Example of Improper Payments due to Insufficient Documentation - Missing order & Missing documentation to support medical necessity

A provider billed an APC payment line for HCPCS code 96372 (Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular) with APC code 00437 (Level II Drug Administration). The service of HCPCS code J3420 (Vitamin B-12 injection) was a packaged service under APC code 00437.

The provider submitted the following:

- Medication administration record

An additional request for documentation returned no documentation. The submitted records were missing the provider's order for the B-12 injection and documentation supporting the medical necessity of the medication. The CERT review contractor scored this claim as an insufficient documentation error and the MAC recovered the payment from the provider.

Resources

You may want to review the following information to help avoid insufficient documentation errors:

- SSA 1862 (a)(1)(A) is available at https://www.ssa.gov/OP_Home/ssact/title18/1862.htm
- 42 CFR 410.32 is available at <https://www.gpo.gov/fdsys/granule/CFR-2011-title42-vol2/CFR-2011-title42-vol2-sec410-32>
- The "Medicare Benefit Policy Manual," Chapter 15, Section 80.6 on Requirements for Ordering and Following Orders for Diagnostic Tests is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>
- The "Medicare Program Integrity Manual," Chapter 3, Section 3.3.2.4 on Signature Requirements and Section 3.3.2.5 on Amendments, Corrections and Delayed Entries in the Medical Documentation is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf>
- Hospital Outpatient Prospective Payment System is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf>
- Find the LCD that applies to your jurisdiction using the Medicare Coverage Database at <https://www.cms.gov/medicare-coverage-database/>.
- The CERT Program website is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/index.html>
- The CERT provider website is available at <https://certprovider.admedcorp.com/>

RECOVERY AUDITOR FINDING: LOWER LIMB SUCTION VALVE PROSTHETICS**DMES****Provider Types Affected: Durable Medical Equipment (DME) Suppliers****Description of the Special Study:**

The Recovery Auditor looked at claims in DME Region D for lower limb suction valve prosthetics to look at potential improper payments related to the following HCPCS codes:

- L5671 - Addition to lower extremity, below knee / above knee suspension locking mechanism (shuttle, lanyard or equal), excludes socket insert
- L5652 - Addition to lower extremity, suction suspension, above knee or knee disarticulation socket
- L5647 - Addition to lower extremity, below knee suction socket

Codes L5647 and L5652 describe a modification to a prosthetic socket that incorporates a suction valve in the design. The items described by these codes are not components of a suspension locking mechanism (L5671). The L5647 and L5652 comprise a different mechanism for attaching the prosthetic.

According to the coding guidelines in Medicare Local Coverage Policy Article [A52496](#), codes L5647 and L5652 describe a modification to a prosthetic socket that incorporates a suction valve in the design. The items described by these codes are not components of a suspension locking mechanism (L5671). Therefore, L5647 and L5652 cannot be billed for the same limb as L5671, on the same date of service.

In conducting the study, the Recovery Auditor examined paid claims with a HCPCS codes L5647 and L5652 and the same date of service for the same beneficiary claim for the same date with HCPCS code L5671. The Recovery Auditor eliminated from the study those claims where the L5647 and L5652 are on a different limb than the L5671, that is they have different modifiers (LT – left and RT – right) indicating different limbs involved.

WHAT YOU SHOULD KNOW

According to the coding guidelines in Medicare Local Coverage Policy Article [A52496](#), codes L5647 and L5652 describe a modification to a prosthetic socket that incorporates a suction valve in the design.

HELPFUL LINKS

[Chapter 15, Section 130](#) in the “Medicare Benefit Policy Manual”.

Findings:

Based on their review, the Recovery Auditor identified a number of claims with improper payments. Based on the Medicare Local Coverage Policy Article [A52496](#) for Lower Limb Prosthetics, the identified claims contain improper payments because the suction valve code in question must not be paid with the suspension locking mechanism code according to the LCD. Further, the Recovery Auditor determined these results also serve as good cause to reopen the claim, if required by [42 CFR 405.980\(b\) \(2\)](#).

Guidance on How Suppliers Can Avoid These Errors:

The Centers for Medicare & Medicaid Services encourages suppliers to be familiar with the details of Medicare Coverage Policy Article [A52496](#). Also, coders should carefully review the medical record documentation to assure proper use of codes L5647 and L5652 when also billing for L5671.

Resources

Suppliers may wish to review the following resources:

- Medicare Coverage Policy Article A52496 at <https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52496>
- “Medicare Benefit Policy Manual,” Chapter 15, Section 130 at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>.



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