MEDICARE QUARTERLY PROVIDER COMPLIANCE NEWSLETTER

Guidance to Address Billing Errors

Volume 8, Issue 4

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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 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.

COMPREHENSIVE ERROR RATE TESTING (CERT): SURGICAL DRESSINGS

Provider Types Affected: Durable Medical Equipment (DME) Suppliers and Physicians/Non-Physician Practitioners (NPPs) who write prescriptions for surgical dressings

Background: Surgical dressings are covered under the surgical dressings benefit (Social Security Act 1861 (s) (5)). Suppliers must meet the provisions set out in Local Coverage Determinations (LCD) L33831 and Surgical Dressings Policy Article A54563.

Description: The CERT contractor reviewed claims for surgical dressings for the 2017 report period. Surgical dressings are:

- Limited to primary and secondary dressings
  - Primary dressings are therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin
  - Secondary dressings are materials that serve a therapeutic or protective function and that are needed to secure a primary dressing (for example, adhesive tape, roll gauze, bandages, and disposable compression material)

- Required for the treatment of a wound caused by, or treated by, a surgical procedure that has been performed by a physician or other health care professional to the extent permissible under State law
- Required after debridement of a wound, irrespective of the type of debridement, as long as the debridement was reasonable and necessary and was performed by a health care professional acting within the scope of his/her legal authority when performing this function
- Covered for as long as they are medically necessary

Finding: Insufficient Documentation Causes Most Improper Payments

For the 2017 report period, the improper payment rate for surgical dressings was 71.3 percent, accounting for 0.3 percent of the overall Medicare Fee-for-Service improper payment rate. The projected improper payment amount for surgical dressings during the 2017 report period was $126.9 million. The majority of improper payments were due to insufficient documentation errors which means that something was missing from the submitted medical records to support payment for the items billed.

Most surgical dressing claims with insufficient documentation lacked:

- A valid physician/NPP's order that includes all elements required by regulation, Medicare program manuals, and Medicare Administrative Contractor (MAC) specific guidelines (for example, physician signature or date, type of dressing, frequency of dressing change, expected duration of need)
- Clinical documentation of wound evaluation as required by the LCD (for example, type of wound, wound location(s), amount of drainage)

Example of Improper Payments due to Insufficient Documentation – Missing clinical documentation of wound evaluation

A supplier billed for Healthcare Common Procedure Coding System (HCPCS) code A6212 (Foam dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing) and in response to the CERT review contractor's request for documentation, the following was submitted:

- Treating physician's detailed written order
- Treating physician's clinical records (dated two weeks prior to the order date) documenting beneficiary with a stage two pressure ulcer with no exudate
- Treating physician's clinical record (dated three days after the order date) documenting stage two pressure ulcer with light exudate
- Proof of delivery

Additional requests to the treating physician for documentation to support the HCPCS code billed returned no documentation. The clinical records submitted were insufficient to support that the beneficiary had a full thickness wound with moderate to heavy exudate as required by the LCD for the billed HCPCS code. 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 a valid order as required by regulation, Medicare program manuals, and MAC specific guidelines

A physician billed for HCPCS A6021 (Collagen dressing, sterile, size 16 sq. in. or less, each) and in response to the CERT review contractor's request for documentation, the following was submitted:

- Treating physician's clinical records documenting a debrided sacral wound with wound measurements
- Treating physician's written order that is not detailed (such as, missing frequency of dressing change)
- Proof of delivery

Additional requests to the provider for documentation to support the HCPCS code billed returned no documentation. The provider failed to submit medical record documentation that was sufficient to support the claim per LCD and Medicare requirements. The CERT review contractor scored this claim as an insufficient documentation error and the MAC recovered the payment from the billing provider.

Resources:

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

- SSA 1861 (s) (5), which is available at https://www.ssa.gov/OP_Home/ssact/title18/1861.htm
- 42 CFR 424.5 (a)(6), which is available at https://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol3/pdf/CFR-2007-title42-vol3-sec424-5.pdf
- Medicare Benefit Policy Manual, Chapter 15, Section 100, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
- LCD L33831, which is available at https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33831
- Local Coverage Article: Surgical Dressings – Policy Article A54563, which is available at https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=54563
- The CERT provider website, which is available at https://certprovider.admedcorp.com
- The CERT Program website, which is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/index.html

RECOVERY AUDITOR ISSUE: REMINDER OF MEDICARE COVERAGE OF VAGUS NERVE STIMULATION (VNS)

Provider Types Affected: Outpatient Hospital, Ambulatory Surgery Center (ASC)

Background: Vagus Nerve Stimulation (VNS) is a pulse generator, similar to a pacemaker, that is surgically implanted under the skin of the left chest and an electrical lead (wire) is connected from the generator to the left vagus nerve. Electrical signals are sent from the battery-powered generator to the vagus nerve via the lead. These signals are in turn sent to the brain.

Effective for services performed on or after July 1, 1999, VNS **is** reasonable and necessary for patients with medically refractory partial onset seizures for whom surgery is not recommended or for whom surgery has failed.

Effective for services performed on or after July 1, 1999, VNS is **not** reasonable and necessary for all other types of seizure disorders which are medically refractory and for whom surgery is not recommended or for whom surgery has failed.

Effective for services performed on or after May 4, 2007, VNS is **not** reasonable and necessary for resistant depression.

On August 7, 2006, a formal request to reconsider resistant depression as an additional indication initiated a national coverage analysis. CR5612 communicates the findings of that analysis. Specifically in CR5612, CMS announces that it has reviewed the evidence and has concluded that VNS is not reasonable and necessary for the treatment of resistant depression under §1862(a)(1)(A) of the Social Security Act. The Centers for Medicare & Medicaid Services (CMS) issued a national noncoverage determination for this indication. Therefore, effective May 4, 2007, CMS will deny or reject, as appropriate, VNS claims for resistant depression, as specified in the Medicare National Coverage Determinations Manual, Chapter 1, Part 2 (Sections 90 – 160.25 (Coverage Determinations)), Section 160.18 VNS, Subsection C (Nationally Non-Covered Indications).

One of the following ICD-10-CM diagnosis codes must be reported, as appropriate, when billing for VNS:

- G40.011 Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, intractable, with status epileptic
- G40.019 Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, intractable, without status epilepticus
- G40.111 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, with status epilepticus
- G40.119 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, without status epilepticus
- G40.211 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, with status epilepticus
- G40.219 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, without status epilepticus

Finding: Medical Necessity and Insufficient Documentation Cause Most Improper Payments

- Claims will be denied as not medically necessary when the patient's medical records indicate VNS is being used as a treatment for resistant depression or other types of seizure disorders besides those covered. Medical records must document and support that the patient has medically refractory **partial onset** seizures for which surgery is not recommended or for which surgery has failed.
- Insufficient documentation errors occur when the medical records submitted were either missing or inadequate to support payment for the billed services.

Resources:

You can find more information about VNS coverage in the following documents:

- Title XVIII of the Social Security Act: Section 1833(e), which is available at https://www.ssa.gov/OP_Home/ssact/title18/1833.htm
- Title XVIII of the Social Security Act: Section 1862(a)(1)(A), which is available at https://www.ssa.gov/OP_Home/ssact/title18/1862.htm
- The Medicare National Coverage Determinations Manual, Chapter 1, Part 2; Section 160.18, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part2.pdf
- The Medicare Claims Processing Manual, Chapter 32, Section 200, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf
- MLN Matters Article MM5612, which is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM5612.pdf

RECOVERY AUDITOR FINDING: AUTOMATED CATARACTS ONCE PER LIFETIME

Provider Types Affected: Physicians and non-physician practitioners providing cataract removal services to qualified Medicare beneficiaries

Problem Description: The Centers for Medicare & Medicaid Services (CMS) Recovery Auditors have identified overpayments associated to outpatient hospital providers and Ambulatory Surgical Centers (ASCs) that bill more than one unit of cataract removal for the same eye for the same date of service. Any time multiple codes within the appropriate code set are billed for the same eye, overpayments may result. Providers submitting claims for more than one unit of cataract removal for the same eye, on the same claim line, will have such lines denied.

Medicare Policy: According to Chapter 8, Section D.3. of the National Correct Coding Initiative (NCCI) Policy Manual, Common Procedure Terminology (CPT), "codes describing cataract extraction (66830-66984) are mutually exclusive of one another. Only one code from this CPT code range may be reported for an eye."

In addition, MLN Matters Article SE1319 states that CMS policy dictates that cataract removal can only occur once per eye.

As stated in the NCCI Policy Manual, Medicare policy dictates that since cataract removal codes are mutually exclusive of each other, providers may not report multiple codes within the established CPT code range for the same eye on the same date of service. **Note:** This is true even if more than one technique is used or more than one code could be applicable.

Finding: MLN Matters Article SE1319 presents two examples of improper billing related to cataract removal, including:

Example 1: For Date of Service (DOS) 10/20/09 the provider billed and received reimbursement for code 66852 LT modifier and also 66984 LT modifier. Since these codes are mutually exclusive of one another only one code should have been reimbursed. Per the NCCI Policy Manual CPT codes describing cataract extraction (66830-66984) are mutually exclusive of one another. Only one code from this CPT code range may be reported for an eye. Therefore Medicare recovered payment for CPT code 66984.

Example 2: For DOS 11/23/10 the provider billed and received reimbursement for 2 units of code 66984 RT modifier. Since cataract removal can only occur once per eye for the same date of service this would be an overpayment. Medicare would adjust the units down to 1 unit for this claim line.

Resources:

You may want to review the following information to help avoid errors in billing for cataract removal:

- The Medicare Program Integrity Manual, Chapter 3, Section 3.6, available for review at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf
- The NCCI Policy Manual, Chapter 8, Section D, which is available for review at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/NCCI-Policy-Manual-2018.zip
- MLN Matters article SE1319, which is available for review at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1319.pdf

RECOVERY AUDITOR FINDING: BLOOD GLUCOSE MONITOR DEVICE BUNDLING

Provider Types Affected: Durable Medical Equipment (DME) Suppliers

Problem Description: Certain blood glucose monitor (BGM) supplies are included in the allowance for a blood glucose monitor device when provided at the same time, and thus are not separately payable. Recovery Auditors have identified overpayments related to unbundling certain supplies billed with a BGM.

Medicare Policy: According to LCD L33822, therapeutic Continuous Glucose Monitor (CGM) devices replace a standard home blood glucose monitor (HCPCS codes E0607, E2100, E2101) and related supplies (HCPCS codes A4233-A4236, A4244-A4247, A4250, A4253, A4255-A4259). Claims for a BGM and related supplies, billed in addition to an approved CGM device (code K0554) and associated supply allowance (code K0553), will be denied. Refer to the Coding Guidelines in the LCD-related Policy Article for additional information.

In addition Medicare policy article A52464 states that the supply allowance for supplies used with a therapeutic CGM system encompasses all items necessary for the use of the device and includes, but is not limited to: CGM sensor, CGM transmitter, home BGM and related BGM supplies (test strips, lancets, lancing device, calibration solutions) and batteries. Supplies or accessories billed separately will be denied as unbundling.

Remember that for blood glucose monitors (codes E0607, E2100, E2101) and related supplies (codes A4233-A4236, A4244-A4247, A4250, A4253, A4255-A4259) and therapeutic CGM devices (code K0554) and supply allowance (code K0553), the following modifiers must be added to the code(s) on every claim submitted:

- Use modifier KX if the beneficiary is insulin treated.
- Use modifier KS if the beneficiary is non-insulin treated.

Finding: Recovery Auditors did identify claims with improper payments. In accordance with A52464 and L33822 certain BGM supplies are included in the allowance for a BGM when provided at the same time. The Recovery Auditors recomended recovering overpayments from the suppliers for the identified claims.

Resources:

You may want to review the following information to help avoid errors in billing for CGM/BGM and related supplies:

- Medicare Policy Article A52464, which is available at https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52464
- LCD L33822, which is available at https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33822
- An Overview of Medicare Covered Diabetes Supplies and Services, MLN Matters Article SE0738, which is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0738.pdf

RECOVERY AUDITOR REMINDER: DOCUMENTATION MUST SUPPORT MEDICAL NECESSITY OF SKILLED NURSING FACILITY CARE

Provider Types Affected: Physicians, non-physician practitioners (NPPs), and providers who bill for services related to beneficiaries in Skilled Nursing Facilities (SNFs)

Problem Description: The Recovery Auditor has identified SNF claims billed on TOB 21X (SNF Inpatient) for review to ensure that medical necessity is properly documented and the documentation supports that the beneficiary received Skilled Nursing Services or Skilled Rehabilitation Services during all assessment periods.

Guidance on How Providers Can Avoid These Problems

Extended Care Services: The submitted documentation must include physician orders for the resident's immediate care. (42 C.F.R. §483.20) The submitted documentation should include the following, initial certification, first recertification (14-day recertification), subsequent recertifications (30-day recertifications), or a facility utilization review plan. The first recertification must be made no later than the 14th day of the SNF stay, as stated in the Medicare General Information, Eligibility and Entitlement, Chapter 4, Section 40.4. Subsequent recertifications must be made at intervals not exceeding 30 days.

The certification/recertifications must be signed by one of the following, the physician responsible for the case, a physician on the SNF staff (with the authorization of the physician responsible for the case), a physician who is available in case of emergency and has knowledge of the case, (with the authorization of the physician responsible for the case), or a physician extender (a nurse practitioner, a clinical nurse specialist, or a physician assistant) (Medicare General Information, Eligibility and Entitlement, Chapter 4, Section 40.1)

Therapy Services Coverage: Coverage for skilled therapy services does not turn on the presence or absence of a beneficiary's potential for improvement from therapy services, but rather on the beneficiary's need for skilled care. Therapy services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a qualified therapist. (See 42 CFR §409.32) These skilled services may be necessary to improve the patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

If all other requirements for coverage under the SNF benefit are met, such skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of the rehabilitation services. (Medicare Benefits Policy Manual (MBPM), Chapter 8, Section 30.4)

Skilled Physical Therapy: The services must be directly and specifically related to an active written treatment plan (MBPM, Chapter 8, Section 30.4.1.1). The treatment plan must be approved by the physician (after any needed consultation with the qualified physical therapist) The services must be of a level of complexity and sophistication, or the condition of the patient of such a nature that requires the judgment, knowledge, and skills of a qualified physical therapist.

Maintenance Therapy: For Speech-Language Pathology therapy, the medical record must document specific circumstances in which speech-language pathology therapy is appropriate in connection with a maintenance program (MBPM, Chapter 8, Section 30.4.2).

For Occupational Therapy, the medical record must document specific circumstances in which occupational therapy is appropriate in connection with a maintenance program (MBPM, Chapter 8, Section 30.4.3).

According to the Medicare Benefits Policy Manual, Skilled Physical Therapy services must meet all the following conditions:

1. The services are directly and specifically related to an active written treatment plan that is based upon an initial evaluation performed by a qualified physical therapist after admission to the SNF and prior to the start of physical therapy services in the SNF that is approved by the physician after any needed consultation with the qualified physical therapist.

2. The services are of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified physical therapist.
3. The services are reasonable and necessary for the treatment of the patient's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.
4. Did the beneficiary receive services that were not skilled and therefore did not meet medical necessity requirements? Was the condition a special medical complication which would require skilled services?

Resources:

You can find more information on how to document medical necessity on claims for SNF services at:

- 42 CFR 409.30-409.36, which is available at https://www.gpo.gov/fdsys/pkg/CFR-2017-title42-vol2/xml/CFR-2017-title42-vol2-part409.xml
- 42 CFR 424.20, which is available at https://www.gpo.gov/fdsys/pkg/CFR-2017-title42-vol3/xml/CFR-2017-title42-vol3-part424.xml
- 42 CFR 483.20, which is available at https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-sec483-20.pdf
- Medicare General Information, Eligibility and Entitlement Manual, Chapter 4, Sections 40.4-40.5, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c04.pdf
- Medicare Program Integrity Manual, Chapter 6, Sections 6.1, and 6.3, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c06.pdf
- Medicare Benefit Policy Manual, IOM 100-02, Chapter 8, Sections 20-40, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf
- Medicare Benefit Policy Manual, IOM 100-02, Chapter 15, Section 220.1.3, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.PDF