DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Medicare Quarterly Provider Compliance Newsletter

Guidance to Address Billing Errors

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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.

Comprehensive Error Rate Testing (CERT): Automatic External Defibrillators

Provider Types Affected: **Physicians (including Physician Assistants, Nurse Practitioners, and Clinical Nurse Specialists) and DME Suppliers**

Background

The CERT program reports detailed results annually in "The Supplementary Appendices." During the 2015 report period (claims submitted from July 1, 2013, through June 30, 2014), the improper payment rate for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) was 39.9 percent, with projected improper payments of approximately $3.2 billion.

The Healthcare Common Procedure Coding System (HCPCS) code for an automatic external defibrillator (AED), with integrated electrocardiogram analysis, garment type, is K0606. Garment type AEDs are also referred to as wearable AEDs.

A wearable AED is covered for beneficiaries if they meet one of the criteria (1-4) described below:

1. A documented episode of ventricular fibrillation or a sustained, lasting 30 seconds or longer, ventricular tachyarrhythmia. These dysrhythmias may be either spontaneous or induced during an electrophysiologic (EP) study, but may not be due to a transient or reversible cause and not occur during the first 48 hours of an acute myocardial infarction; or
2. Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmia such as long QT syndrome or hypertrophic cardiomyopathy; or
3. Either documented prior myocardial infarction or dilated cardiomyopathy and a measured left ventricular ejection fraction less than or equal to 0.35; or
4. A previously implanted defibrillator now requires explantation.

Finding: Insufficient Documentation Causes Most Improper Payments

Eighty-three percent of improper payments for DMEPOS were due to insufficient documentation. Insufficient documentation means that something was missing from the medical records. The most common items missing from the submitted documentation for DMEPOS are physician signatures, medical record documentation to support medical necessity, and lack of support for the date of delivery.

Face-to-Face Visit Requirements

As a condition for payment, Section 6407 of the Affordable Care Act requires that a physician (MD, DO or DPM), physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS) has had a face-to-face examination with a beneficiary that meets all of the following requirements:

- The treating physician must have an in-person examination with the beneficiary within the 6 months prior to the date of the written order prior to delivery (WOPD); and
- This examination must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered.

The treating practitioner that conducted the face-to-face examination does not need to be the prescriber for the DME item. However, the prescriber must:

- Verify that the in-person visit occurred within the 6 months prior to the date of their prescription;
- Have documentation of the face-to-face examination that was conducted; and
- Provide the DMEPOS supplier with copies of the in-person visit records.

Prior to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), physicians were required to document face-to-face encounters conducted by allowed nurse practitioners, physician assistants, or clinical nurse specialists. For dates of service on or after November 10, 2015, a physician is no longer required to co-sign and date face-to-face encounters performed by non-physician practitioners (See the "Medicare Program Integrity Manual" (PIM), **Chapter 5**, Section 5.2.5.2.)

Example of an Improper Payment for an Automatic External Defibrillator due to Insufficient Documentation – Missing Co-signature and Date Stamp

A medical supply company billed for a wearable AED (HCPCS K0606), for a date of service in November 2014. The documentation submitted, in response to an initial request for medical records, included a detailed order signed and dated by a physician in October 2014 with a date stamp (to show that the medical supply company had received it on or before the date of delivery), a face-to-face encounter dated September 2014 signed by the NP with a date stamp but without a physician co-signature and date, and a face-to-face encounter dated in October 2014 signed by the NP without a date stamp and without a physician co-signature and date. The face-to-face encounter in October 2014 documented a myocardial infarction in 2004; cardiomyopathy and a left ventricular ejection fraction of 30 percent; dyspnea on exertion; the NP's assessment that the beneficiary is a candidate for the wearable AED; an EKG and echocardiogram dated in September 2014; and proof of delivery dated October 2014.

Therefore, the submitted face-to-face encounter documentation is missing the date stamp (to show that the medical supply company had received it on or before the date of delivery) and missing the physician co-signature and date. This claim was scored as an improper payment due to an insufficient documentation error.

Example of an Improper Payment for an Automatic External Defibrillator due to Insufficient Documentation – Missing Signatures and Date Stamp

A medical supply company billed for a wearable AED (HCPCS K0606), for a date of service in November 2014. The documentation submitted, in response to an initial request for medical records, included a proof of delivery dated July 2014, a detailed order signed and dated by a physician in July 2014 with a date stamp (to show that the medical supply company had received it on or before the date of delivery); a face-to-face encounter dated in July 2014 signed by the physician after the date of delivery of the AED and without a date stamp; an unsigned cardiac catheterization report without a date; and an echocardiogram signed in June 2014.

Therefore, the submitted face-to-face encounter documentation is missing the date stamp (to show that the medical supply company had received it on or before the date of delivery) and missing the physician signature and date. This claim was scored as an improper payment due to an insufficient documentation error.

Resources

- ✓ Local Coverage Articles and Local Coverage Determinations (LCDs) are available at **https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx**;
- ✓ With regard to automatic external defibrillators, policy article A52458 is available at **https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52458**.
- ✓ Chapter 5 of the "Medicare Program Integrity Manual" is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c05.pdf**.

The Medicare Learning Network® has a series of **CMS Provider Minute videos** on compliance for Part A and Part B providers and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers. These videos have tips to help you properly submit claims with sufficient documentation in order to receive correct payment the first time

Comprehensive Error Rate Testing (CERT): Treprostinil Inhalation Solution

Provider Types Affected: **Physicians (including Physician Assistants, Nurse Practitioners, and Clinical Nurse Specialists) and DMEPOS Suppliers.**

Background

Treprostinil inhalation solution is used for treating pulmonary arterial hypertension (PAH) (high blood pressure in the arteries of the lungs). Treprostinil inhalation solution works by relaxing blood vessels and increasing the supply of blood to the lungs in patients with high blood pressure in the lungs. Treprostinil inhalation solution is inhaled through the mouth into the lungs.

J7686 is the HCPCS code for Treprostinil, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 1.74 mg.

A small volume ultrasonic nebulizer (E0574) and related accessories are reasonable and necessary to administer Treprostinil inhalation solution only. Claims for code E0574 used with other inhalation solutions will be denied as not reasonable and necessary.

Treprostinil inhalation solution (J7686) is covered when all of the following criteria (1-3) are met:

1. The beneficiary has a diagnosis of pulmonary artery hypertension;
2. The pulmonary hypertension is not secondary to pulmonary venous hypertension (for example, left sided atrial or ventricular disease and left sided valvular heart disease) or disorders of the respiratory system (for example, chronic obstructive pulmonary disease, interstitial lung disease, obstructive sleep apnea or other sleep disordered breathing, and alveolar hypoventilation disorders);
3. The beneficiary has primary pulmonary hypertension or pulmonary hypertension which is secondary to one of the following conditions: connection tissue disease, thromboembolic disease of the pulmonary arteries, human immunodeficiency virus (HIV) infection, cirrhosis, anorexigens or congenital left or right shunts. If these conditions are present, the following criteria (a-d) must be met:
    a. The pulmonary hypertension has progressed despite maximal medical and/or surgical treatment of the identified condition;
    b. The mean pulmonary artery pressure is > 25 mm Hg at rest or > 30 mm Hg with exertion;
    c. The beneficiary has significant symptoms from the pulmonary hypertension (that is, severe dyspnea on exertion, and either fatigability, angina, or syncope); and
    d. Treatment with oral calcium channel blocking agents has been tried and failed, or has been considered and ruled out.

Nebulizer Machines and Related Medications

Medicare provides coverage for medically necessary nebulizer machines and related medications. A nebulizer machine is a device that uses pressurized air to convert liquid medicine into an easily inhaled fine mist.

The CERT program reports detailed results annually in "**The Supplementary Appendices**." During the 2015 report period (claims submitted from July 1, 2013, through June 30, 2014), the improper payment rate for nebulizer machines and related medications was 11.0 percent, accounting for 0.3 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for nebulizer machines and related medications during the 2015 report period was $125 million. A significant amount of improper payments is due to claims for Treprostinil inhalations.

The majority of improper payments for nebulizer machines and related medications were due to insufficient documentation. There must be a written order from the treating physician that specifies the name of the dispensed solution, the correct dosage and frequency, and the instructions for administration. Medicare also requires documentation from the treating physician that supports the medical necessity of the nebulizer and inhalation medications.

The ordering and referring provider specialties of Internal Medicine and Family Practice comprise the majority of improper payments for nebulizer machines and related medications. In order to reduce the improper payment rate for nebulizer machines and related medications, the referring providers must respond to requests for documentation.

Proof of Delivery

Suppliers are required to maintain proof of delivery documentation in their files. Documentation must be maintained in the supplier's files for 7 years.

Proof of delivery is required in order to verify that the beneficiary received the nebulizer, which is in the DMEPOS category. Proof of delivery is one of the supplier standards as noted in **42 CFR, 424.57(12)** and documentation must be made available to the Medicare contractor upon request. For any services, which do not have proof of delivery from the supplier, such claimed items and services shall be denied and overpayments recovered. Suppliers who consistently do not provide documentation to support their services may be referred to the OIG for investigation and/or imposition of sanctions (**PIM Chapter 4, Section 4.26**).

Finding: Insufficient Documentation Causes Most Improper Payments

Insufficient documentation means that something was missing from the medical records. The most common items missing from the submitted documentation for DMEPOS are physician signatures, medical record documentation to support medical necessity, documentation of an in-person examination with the beneficiary within the 6 months prior to the date of the written order prior to delivery (WOPD) and lack of support for the date of delivery.

Example of an Improper Payment for Treprostinil due to Insufficient Documentation – Missing Detailed Order; Missing Proof of Delivery

A pharmacy billed for Treprostinil inhalation solution (unit dose=1.74 mg, 28 units of service and the associated pharmacy dispensing fee) and for the monthly rental of a small volume ultrasonic nebulizer for a date of service in January 2014. Although an order for the Treprostinil was submitted, it did not include the required information nor was there documentation of shipping and delivery. The submitted documentation did not include the following requirements;

1. Detailed written order for the Treprostinil inhalation solution that includes the name of the drug and the concentration of the drug in the dispensed solution and the volume of solution in each container, OR the name of the drug and the number of milligrams/grams of drug in the dispensed solution and the volume of solution in that container;
2. Detailed written order for the nebulizer; and
3. Clinical documentation from the treating physician to support the medical necessity for the billed items.

This claim was scored as an improper payment due to an insufficient documentation error.

Example of Improper Payment for Treprostinil due to Insufficient Documentation – Missing Detailed Order

A pharmacy billed for Treprostinil inhalation solution for a date of service in October 2014. The submitted order did not include the concentration of the drug in the dispensed solution or the volume of each container. Submitted documentation included:

1. Proof of delivery dated in December 2014;
2. Office visit notes dated April 2014 to support the diagnosis of PAH secondary to congenital left to right shunts, unresponsive to nitric oxide per cath report; rare chest pain occurring once per month, shortness of breath with activity, rare palpitations once per month lasting a few seconds;

3. Catheterization report dated in 1999 with a mean PA pressure of 89 mmHg, no significant decrease in pulmonary vascular resistance with short-term aggressive pulmonary vasodilator therapy;
4. Catheterization report dated 2002;
5. Echocardiograms performed in 2011, 2012, and 2014;
6. A stress test from 2013;
7. A CT angiogram from May 2014; and
8. A refill request dated December 2014.

This claim was scored as an improper payment due to an insufficient documentation error.

Example of Improper Payment for Treprostinil due to Insufficient Documentation – Missing Proof of Delivery

A pharmacy billed for Treprostinil inhalation solution and the associated pharmacy dispensing fee for a date of service in September 2014. The pharmacy submitted:

1. An order dated March 2014 with sufficient detail including the concentration of the drug in the dispensed solution and the volume of solution in each container;
2. Calcium Channel Blocker (CCB) statement indicating CCB not tried due to lack of response to vasodilator challenge dated April 2011;
3. A pulmonologist's consultation dated April 2011 stating that the patient's PAH was associated with limited scleroderma, oxygen dependency, shortness of breath, and a mean pulmonary artery pressure > 25 mm Hg;
4. Additional progress notes more than 12 months prior to the date of service that supported CREST syndrome, clinical decline with right heart failure, multiple treatments initiating Treprostinil therapy in May 2011;
5. Clinical notes from 2013 and 2014 that support continuing medical necessity and use of the inhalation Treprostinil; and
6. Diagnostics reports that support PAH.

However, the pharmacy did not provide proof of delivery despite additional requests for this documentation. This claim was scored as an improper payment due to an insufficient documentation error.

Resources

You will find more information on avoiding insufficient documentation errors in the following resources:

- ✓ Chapter 4.26 of the "Program Integrity Manual" is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c04.pdf**;
- ✓ CERT Supplementary Appendices reports are available at **https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports.html**; and
- ✓ 42 CFR 424.57 is available at **https://www.gpo.gov/fdsys/pkg/CFR-2005-title42-vol2/pdf/CFR-2005-title42-vol2-sec424-57.pdf**.

Comprehensive Error Rate Testing (CERT): Therapeutic Shoes for Persons with Diabetes

Provider Types Affected: **Physicians and DMEPOS Suppliers**

Background

Medicare covers therapeutic shoes or inserts for beneficiaries with diabetes who have severe diabetic foot disease. The physician who treats a beneficiary with diabetes must certify that the beneficiary needs therapeutic shoes or inserts. A podiatrist or other qualified doctor must prescribe the shoes and inserts, as they are Durable Medical Equipment, Prosthetics and Orthotics (DMEPOS) items. A doctor or other qualified individual like a pedorthist, orthotist, or prosthetist must fit and provide the shoes. Medicare Part B covers the furnishing and fitting of either one pair of custom-molded shoes and inserts or one pair of extra-depth shoes each calendar year. Medicare Part B also covers 2 additional pairs of inserts each calendar year for custom-molded shoes and three pairs of inserts each calendar year for extra-depth shoes. Medicare Part B will also cover shoe modifications instead of inserts.

The CERT program reports detailed results annually in "**The Supplementary Appendices**." During the 2015 report period, the improper payment rate for therapeutic shoes for persons with diabetes (also referred to as Diabetic Shoes) was 66 percent, with projected improper payments of approximately $119 million. Improper payments for therapeutic shoes for persons with diabetes accounted for 0.3 percent of the overall improper payment rate during the 2015 report period.

Frequently used HCPCS codes for therapeutic shoes and inserts for patients with diabetes are:

- A5500 - For diabetics only, fitting (including follow-up), custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multi-density insert(s), per shoe
- A5501 - For diabetics only, fitting (including follow-up), custom preparation and supply of shoe molded from cast(s) of patient's foot (custom molded shoe), per shoe
- A5512 - For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), prefabricated, each
- A5513 - For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer or higher), includes arch filler and other shaping material, custom fabricated, each

Additional coding guidelines are available in Local Coverage Articles, for example **A52501**.

Finding: Insufficient Documentation Causes Most Improper Payments

Ninety percent of improper payments for therapeutic shoes for persons with diabetes were due to insufficient documentation. Insufficient documentation means that something was missing from the medical records. The most common items missing from the submitted documentation are the "Statement of Certifying Physician for Therapeutic Shoes," medical record documentation to support the "Statement of Certifying Physician for Therapeutic Shoes," and documentation of the in-person evaluation of the beneficiary by the supplier at the time of selecting the items.

Required: "Statement of Certifying Physician for Therapeutic Shoes"

The supplier must obtain a signed statement from the physician who is managing the beneficiary's systemic diabetes condition (that is, the certifying physician) specifying that the beneficiary has diabetes mellitus, has one of conditions 2a-2f listed in the related Policy Article (excerpt below), is being treated under a comprehensive plan of care for his/her diabetes, and needs therapeutic shoes. The certifying physician must be an MD or DO

and may not be a podiatrist, physician assistant, nurse practitioner, or clinical nurse specialist. The "Statement of Certifying Physician for Therapeutic Shoes" form is recommended (see the Local Coverage Determination (LCD) Attachments section). Whatever form is used must contain all of the elements contained on the recommended form attached to the LCD. This statement must be completed, signed, and dated by the certifying physician. A new Certification Statement is required for a shoe, insert or modification provided more than one year from the most recent Certification Statement on file.

According to the Policy Article, therapeutic shoes, inserts and/or modifications to therapeutic shoes are covered if all of the following criteria are met:

1. The beneficiary has diabetes mellitus; and
2. The certifying physician has documented in the beneficiary's medical record one or more of the following conditions:
    a. Previous amputation of the other foot, or part of either foot;
    b. History of previous foot ulceration of either foot;
    c. History of pre-ulcerative calluses of either foot;
    d. Peripheral neuropathy with evidence of callus formation of either foot;
    e. Foot deformity of either foot;
    f. Poor circulation in either foot; and
3. The certifying physician has certified that indications (1) and (2) are met and that he/she is treating the beneficiary under a comprehensive plan of care for his/her diabetes and that the beneficiary needs therapeutic shoes. For claims with dates of service on or after January 1, 2011, the certifying physician must:
    a. Have an in-person visit with the beneficiary during which diabetes management is addressed within 6 months prior to delivery of the shoes/inserts; and
    b. Sign the certification statement (refer to the Documentation Requirements section of the related Local Coverage Determination) on or after the date of the in-person visit and within 3 months prior to delivery of the shoes/inserts.
4. Prior to selecting the specific items that will be provided, the supplier must conduct and document an in-person evaluation of the beneficiary. (Refer to the related Local Coverage Determination, Documentation Requirements section, for additional information.)
5. At the time of in-person delivery to the beneficiary of the items selected, the supplier must conduct an objective assessment of the fit of the shoe and inserts and document the results. A beneficiary's subjective statements regarding fit as the sole documentation of the in-person delivery does not meet this criterion.

Required: Support for the "Statement of Certifying Physician for Therapeutic Shoes"

Certificates of Medical Necessity (CMN), DME Information Forms (DIF), supplier prepared statements and physician attestations by themselves do NOT provide sufficient documentation of medical necessity, even if signed by the ordering physician (Program Integrity Manual, Chapter 3, Section 3.3.2.1.1.B). Therefore, providers/suppliers must submit documentation in addition to the "Statement of Certifying Physician for Therapeutic Shoes."

Required: An in-person evaluation of the beneficiary by the supplier at the time of selecting the items

The in-person evaluation of the beneficiary by the supplier at the time of selecting the items that will be provided must include at least the following:

1. An examination of the beneficiary's feet with a description of the abnormalities that will need to be accommodated by the shoes/inserts/modifications;
2. For all shoes, taking measurements of the beneficiary's feet; and

3. For custom molded shoes (A5501) and inserts (A5513), taking impressions, making casts, or obtaining CAD-CAM images of the beneficiary's feet that will be used in creating positive models of the feet.

The in-person evaluation of the beneficiary by the supplier at the time of delivery must be conducted with the beneficiary wearing the shoes and inserts and must document that the shoes/inserts/modifications fit properly.

Examples of Improper Payments due to Insufficient Documentation for Therapeutic Shoes for Persons with Diabetes

Insufficient Documentation – Missing a Statement of certifying physician within 3 months prior to delivery of the shoes/inserts

A podiatrist billed for custom molded shoe shoes (HCPCS A5501, 2 units) and multi-density inserts (HCPCS A5513, 6 units), for a date of service in June 2014. The documentation submitted, in response to an initial request for medical records, included proof of delivery; a "Statement of Certifying Physician for Therapeutic Shoes" signed in January 2014; a clinical record from the certifying physician dated in January 2014 that documented paraesthesias in the right lower extremity and diabetes treated with insulin; and an unsigned supplier form dated May 2014 that referred to a scan. Therefore, the requirement for a "Statement of Certifying Physician for Therapeutic Shoes" signed within 3 months prior to delivery of the shoes and inserts was not met.

This claim was scored as an insufficient documentation error.

Insufficient Documentation – Missing documentation of an in-person evaluation of the beneficiary by the supplier at the time of selecting the items.

A podiatrist billed for diabetic shoes (HCPCS A5500, 2 units) and multi-density inserts (HCPCS A5513, 6 units), for a date of service in July 2014. The documentation submitted included a Statement of Certifying Physician dated in July 2014; a podiatrist's progress note dated in July 2014 that documented the fitting and dispensing of diabetic shoes and inserts; and proof of delivery dated in July 2014. In response to additional letters and phone calls requesting documentation, duplicate documentation and a podiatry progress note signed and dated in June 2014 were received. The podiatry progress note from June 2014 documented that the beneficiary was ambulating with discomfort; an examination and nail debridement were performed and the podiatrist noted that the beneficiary's footwear was adequate. The documentation did not include a copy of the in-person evaluation of the beneficiary by the supplier at the time of selecting the billed items. The documentation did not include clinical documentation of an in-person visit within 6 months prior to delivery of the shoes and inserts from the physician managing the beneficiary's diabetes under a comprehensive plan of treatment for diabetes.

This claim was scored as an insufficient documentation error.

Insufficient Documentation – Missing documentation to support the Statement of Certifying Physician; Missing documentation of an in-person evaluation of the beneficiary by the supplier at the time of selecting the items

A podiatrist billed for diabetic shoes (HCPCS A5500, 2 units) and custom fabricated multi-density inserts (HCPCS A5513, 6 units) for a date of service in late June 2014. The documentation submitted, in response to an initial request for medical records, included a podiatry (supplier) note dated in April 2014 which supported a history of diabetes and diminished pulses bilaterally on examination. The documentation submitted also included a podiatry order form for A5500 dated in May 2014, a Statement of Certifying Physician dated in April 2014, a proof of delivery dated in June 2014, and a podiatry note dated in June 2014. The podiatry note documented that the shoes and custom fabricated inserts were dispensed and that an evaluation for proper fit was performed. Despite additional requests for documentation, there was no record of the supplier's in-person evaluation of the patient at the time of selecting the items that met the requirements. Although the certifying physician submitted medical records, the documented physical examination did not support the findings in the podiatrist's notes or the statements made in the Statement of Certifying Physician.

This claim was scored as an insufficient documentation error.

Resources

You will find more information on avoiding insufficient documentation errors in the following resources:

- ✓ Local Coverage Articles and Local Coverage Determinations related to therapeutic shoes is in LCD A52501 at **https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52501**;
- ✓ The "Medicare Benefit Policy Manual," Chapter 15, Section 140 – Therapeutic Shoes for Individuals with Diabetes, available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf**;
- ✓ A fact sheet on podiatry services is available at **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicarePodiatryServicesSE_FactSheet.pdf**; and
- ✓ A booklet on "Medicare Coverage of Durable Medical Equipment and Other Devices" is available at **https://www.medicare.gov/Pubs/pdf/11045.pdf.**

Office of Inspector General Report: Improper Medicare Payments for Hospital Outpatient Dental Services

Provider Types Affected: **Dentists, Hospitals, and Providers performing hospital outpatient dental services**

Background

Medicare does not usually cover dental services unless certain criteria are met. According to Section 1862(a)(12) of the Social Security Act (the Act), Medicare does not cover items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth (for example, preparation of the mouth for dentures). Coverage of dental services requires those services to be performed as incident to and as an integral part of a procedure or service covered by Medicare.

For example, Medicare covers extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw, but a tooth extraction performed because of tooth decay is not covered.

Problem Description

Medicare Administrative Contractors (MACs), for varying periods of time, made potentially ineligible payments for hospital outpatient dental services that are not covered by Medicare. Multiple MACs representing multiple jurisdictions made these payments and samples were audited by the Office of Inspector General (OIG) to determine whether payments made to providers in these jurisdictions for hospital outpatient dental services complied with Medicare requirements.

Audit Finding #1 – Wisconsin Physicians Service Insurance Corporation (WPS) in Jurisdictions 5 & 8:

For a 2-year period beginning January 1, 2013, and ending December 31, 2014, WPS paid providers for hospital outpatient dental services. OIG determined these services might be ineligible for Medicare payments. These potential ineligible payments were made to providers in Jurisdictions 5 (Iowa, Kansas, Missouri, and Nebraska) and 8 (Indiana and Michigan).

The review covered 1,993 hospital outpatient dental services that totaled $1.5 million in payments by WPS to providers in Jurisdictions 5 and 8 during the audit period. A stratified random sample of 100 such services was selected and those providers who received payments were contacted to determine if said services complied with Medicare requirements.

The review showed that 95 percent of the sampled services did not comply with Medicare requirements. Two services in particular – tooth socket repairs and unallowable x-rays – accounted for 77 percent of all unallowable dental services in the sample.

Some reasons given by providers for billing for these unallowable services included:

- Beneficiaries were eligible for both Medicare and Medicaid. Because Medicare was the primary payer for these services, providers were required to submit claims to Medicare first and document that Medicare denied the claims before Medicaid could be billed. However, WPS incorrectly paid the claims.
- Some providers did not always include the appropriate modifier or condition code to signify that services were not eligible for payment.
- One provider believed the outpatient dental services were allowed because of the medical history/condition of the patient (that is, the provider felt it was a medical necessity).
- Some providers inadvertently billed the wrong procedure code.
- One provider said incorrect billing was the result of inadequate edits in the hospital's claims system.

Audit Finding #2 – Novitas Solutions, Inc. in Jurisdiction H:

For an audit period covering January 1, 2012, to August 31, 2014, it was determined that Novitas, along with Pinnacle Business Solutions, Inc., and TrailBlazer Health Enterprises, LLC, paid providers in Jurisdiction H (Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas) for hospital outpatient dental services that OIG determined may be ineligible for Medicare payment.

Novitas began processing claims from each fiscal intermediary on transition dates of August 20, 2012 (Pinnacle) and October 29, 2012 (TrailBlazer) and was fully operational as the MAC for Jurisdiction H on November 19, 2012.

As part of its internal controls, Novitas developed two edits related to hospital outpatient dental services:

- One edit suspended claims for certain dental services. For those claims, the edit system sent a request to the provider for additional documentation, which Novitas' clinical staff reviewed to determine payment eligibility.
- The second edit suspended claims for certain dental services for review by Novitas' claims processors. They reviewed those claims for a diagnosis related to cancer or physical trauma to determine patient eligibility.

A stratified random sample of 100 such services was selected and those providers who received payments were contacted to determine if the services complied with Medicare requirements.

The review showed that 91 percent of the sample claims were paid for tooth socket repairs, which is not a covered service. Combined with unallowable tooth extractions and x-rays, 98 percent of the sample was accounted for. Providers contacted agreed such payments were not in compliance with Medicare requirements and offered the following reasoning:

- Beneficiaries were eligible for both Medicare and Medicaid. Because Medicare was the primary payer for these services, providers were required to submit claims to Medicare first and document that Medicare denied the claims before Medicaid could be billed. However, MACs incorrectly paid the claims.
- Noncovered dental services were incorrectly billed as covered services.

In addition, Novitas denied one claim, but that decision was overturned upon provider appeal. Also, Novitas' edits did not suspend claims for the other 90 ineligible dental services.

Audit Finding #3 – First Coast Service Options, Inc. in Jurisdiction N:

For an audit period covering January 1, 2012, to August 31, 2014, it was determined that First Coast Service Options, Inc. (FCSO), a MAC, paid Jurisdiction N (Florida, Puerto Rico, and the U.S. Virgin Islands) providers for hospital outpatient dental services that OIG determined may be ineligible for Medicare payment.

During the audit period, FCSO developed an edit to suspend claims for certain dental services. For those claims, the edit system sent a request for additional documentation to providers. FCSO manually reviewed the additional documentation sent by providers to determine payment eligibility.

A stratified random sample of 100 such services was selected and those providers who received payments were contacted to determine if said services complied with Medicare requirements.

The review found that in most of the ineligible services reviewed, providers in Jurisdiction N billed Medicare for tooth socket repairs, which is not a covered service. Providers also billed Medicare for unallowable x-rays. These errors accounted for 82 percent of all unallowable dental services in the sample. Other types of unallowable dental services included tooth extractions, gum repair or excision, and oral examinations.

When contacted, 94 of 95 providers agreed that the Medicare payments did not comply with Medicare requirements. One provider disagreed with the OIG assessment and did not respond to a request for a follow-up discussion. FCSO officials were asked to determine whether that payment complied with Medicare requirements and they agreed that it did. Those providers who were successfully contacted offered the following reasoning for the improper payments:

- The majority of providers stated that the unallowable payments occurred because the dental services were missing information indicating that they were ineligible for Medicare payment.
- Other providers stated that the dental services were billed to Medicare for beneficiaries eligible for both Medicare and Medicaid. The providers said that they expected Medicare to deny the services so that they could bill Medicaid. However, FCSO incorrectly paid the claims.
- Other providers stated that inadequate controls caused the billing errors.

In addition, six of the 96 ineligible dental service claims should have been suspended by FCSO's edit, but were not because of program changes made in Medicare's Fiscal Intermediary Shared System (FISS), which processes institutional claims. As a result, these six services were incorrectly paid. Furthermore, FCSO's edit was not programmed to identify and suspend the other 89 ineligible dental services.

Guidance on How Providers Can Avoid These Billing Errors

Providers should review Chapter 15, Section 150 of the "Medicare Benefit Policy Manual" (Pub. 100-02), which details Medicare policy with regard to coverage of dental services. Providers should also note MLN Matters® Article SE0402, which documents a change in Medicare that states that group health plans may not require a dentist to submit a claim to Medicare in order to obtain a denial prior to billing the group health plan for the dental services.

Resources

The following resources are available to assist in complying with Medicare policy with regard to hospital outpatient dental services:

- ✓ The "Medicare Benefit Policy Manual," Chapter 15, Section 150, "Dental Services," is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf**; and
- ✓ MLN Matters Article SE0402, "Treatment of Certain Dental Claims as a Result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003," available at **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0402.pdf**.