



MEDICARE QUARTERLY PROVIDER COMPLIANCE NEWSLETTER

Guidance to Address Billing Errors

Volume 9, Issue 1

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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): THERAPEUTIC SHOES AND INSERTS FOR INDIVIDUALS WITH DIABETES

Provider Types Affected: Physicians, Non-Physician Practitioners (NPPs), Durable Medical Equipment (DME) Suppliers and other qualified individuals as indicated below.

Background: Therapeutic shoes and inserts (hereinafter referred to as “diabetic shoes”) are covered under the therapeutic shoes with inserts for individuals with diabetes benefit ([Social Security Act 1861\(s\)](#) (12)) under Medicare Part B which is a separate category of coverage from that of DME and orthotics. Documentation requirements for diabetic shoes include, but are not limited to, the certification, prescription, and fitting and furnishing of the items.

- Certification: The need for diabetic shoes must be certified by a physician who is a doctor of medicine (M.D.) or a doctor of osteopathy and who is responsible for diagnosing and treating the beneficiary's diabetic systemic condition through a comprehensive plan of care. The certifying physician may not be a podiatrist, physician assistant, nurse practitioner, or clinical nurse specialist. Specific certification requirements are listed in the [Medicare Benefit Policy Manual, Chapter 15, Section 140](#).
- Prescription: After the certification is completed, a podiatrist or other qualified physician, who is knowledgeable in the fitting of diabetic shoes, may prescribe the particular type of items necessary. The prescribing practitioner may also be the supplier.
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- **Fitting and Furnishing:** The diabetic shoes must be fitted and furnished by a podiatrist or other qualified individual such as a pedorthist, an orthotist, or a prosthetist. The certifying physician may not furnish the diabetic shoes unless the certifying physician is the only qualified individual in the area (such as, in a defined rural or health professional shortage area).

Description: The CERT contractor reviewed claims for diabetic shoes for the 2017 report period. The following items may be covered under the diabetic shoe benefit and are included within the claim findings information:

- Custom molded shoes
- Extra-depth shoes
- Inserts

Finding: Insufficient Documentation Causes Most Improper Payments

For the 2017 CERT report period, the improper payment rate for diabetic shoes was 67.8 percent, accounting for 0.3 percent of the overall Medicare Fee-for-Service improper payment rate. The projected improper payment amount for diabetic shoes during the 2017 report period was \$92.3 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 diabetic shoe claims with insufficient documentation lacked one or more of the following:

- Documentation to support the medical necessity of the item(s) (including certification)
- Supplier documentation as required by the [Local Coverage Article A52501](#)
- A valid physician/NPP's order that includes all elements required by regulation, Medicare program manuals, and DME Medicare Administrative Contractor (DME MAC) specific guidelines

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

A supplier billed for Healthcare Common Procedure Coding System (HCPCS) code 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)). In response to the CERT review contractor's request for documentation, the supplier submitted the following:

- Treating physician's detailed written order
- Certification completed and signed by a podiatrist
- Treating physician's clinical records documenting the beneficiary has diabetes and management of the condition
- Supplier documentation of in-person evaluation of the beneficiary
- Proof of delivery

Additional requests to the treating physician for documentation to support the HCPCS code billed returned no documentation. The certification submitted failed to support that the certifying physician was a doctor of medicine or a doctor of osteopathy as required by Medicare policy. The CERT review contractor scored this claim as an insufficient documentation error and the DME MAC recovered the payment from the billing provider.

Example of Improper Payments due to Insufficient Documentation – Missing supplier documentation as required by Medicare and DME MAC specific guidelines

A physician billed for HCPCS 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). In response to the CERT review contractor's request for documentation, the supplier submitted the following:

- Treating physician's detailed written order
- Certification completed and signed by the treating M.D.
- Treating physician's clinical records documenting the beneficiary has diabetes and management of the condition
- Proof of delivery

Additional requests to the supplier for documentation to support an in-person assessment of the fit of the shoe at the time of delivery returned no documentation. The supplier failed to submit medical record documentation that was sufficient to support the claim per [Local Coverage Determination \(LCD\) L33369](#) 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:

- Section 1861(s)(12) of the Social Security Act is available at https://www.ssa.gov/OP_Home/ssact/title18/1861.htm
- Section 1862(a)(1)(A) of the Social Security Act is available at https://www.ssa.gov/OP_Home/ssact/title18/1862.htm
- 42 CFR 424.5 (a)(6) is available at <https://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol3/pdf/CFR-2007-title42-vol3-sec424-5.pdf>
- The "Medicare Benefit Policy Manual" (IOM 100-02), Chapter 15, Section 140 which is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>
- LCD L33369, Therapeutic Shoes for Persons with Diabetes, which is available at <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33369>
- Local coverage article A52501, Therapeutic Shoes for Persons with Diabetes-Policy Article, which is available at <https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52501>
- The CERT provider website is available at <https://certprovider.admedcorp.com>
- 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>

RECOVERY AUDITOR FINDING: OUTPATIENT SERVICE OVERLAPPING OR DURING AN INPATIENT STAY

Provider Types Affected: Hospitals

Problem Description: Medicare may not make payment for outpatient services when such services overlap or occur during an inpatient stay. The jurisdiction for this issue covers all Part A & B Medicare Administrative Contractors (MACs). Analysis of claims that hospitals submitted on Types of Bill (TOB) 12x and 13x shows billing errors due to outpatient services being billed for dates of service when the patient was in an inpatient stay.

The error occurs when outpatient services are provided to a patient who is a Medicare beneficiary and such services overlap with that patient's inpatient stay, or occur during that stay. In such cases, duplicate payments have been issued in error for the inpatient and outpatient services. An automated review was conducted of such cases to determine if Medicare was making duplicate (over)payments.

Medicare Policy: These errors may occur when hospitals do not follow the policies listed in the Medicare Claims Processing Manual, [Chapter 3, Section 40.3](#), which discusses outpatient services that are treated as inpatient services. These services may include pre-admission diagnostic services and other pre-admission services. In addition, [Chapter 4, Section 10.12](#) of the same manual discusses Medicare's policy regarding the payment window for outpatient services treated as inpatient services.

Finding: The Recovery Auditors' automated review of claims uncovered a number of overpayments due to non-adherence of these policies and the MACs took action to recover those overpayments.

Resources:

You may want to review the following information to help avoid these billing errors:

- The Medicare Claims Processing Manual, Chapter 3, Section 40.3 is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf>.
- The Medicare Claims Processing Manual, Chapter 4, Section 10.12, is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf>.