

# Medicare Provider Compliance Newsletter

## Guidance to Address Billing Errors

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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 current top mistakes.

The Medicare FFS Program processes more than 1 billion claims each year. Medicare Administrative Contractors (MACs) process these claims and make payments to more than 1 million health care professionals based on Medicare regulations. They also provide education on how to submit accurately coded claims.

Despite actions to prevent improper payments, it's impossible to prevent them all due to the large volume of claims. The Medicare Learning Network's® Medicare Provider Compliance Newsletter helps health care professionals understand the latest findings by MACs and other contractors such as Recovery Auditors and the Comprehensive Error Rate Testing (CERT) Review Contractor. Also, other governmental organizations, such as the Office of the Inspector General (OIG), conduct reviews and identify issues.

We (CMS) release the newsletter twice each year.



Physicians



Non-Physician  
Practitioners



Hospitals



Durable Medical  
Equipment Supplier



Nurse  
Practitioners



Doctor of  
Osteopathy



Medical Doctors



Professional  
Services

**COMPREHENSIVE ERROR RATE TESTING (CERT): HOSPICE CERTIFICATION AND RECERTIFICATION OF TERMINAL ILLNESS****Provider Types Affected:**

- Physicians
- Medical doctors
- Doctors of Osteopathy
- Nurse Practitioners

**Background:** Medicare Part A covers the hospice benefit when a patient gets care from a certified hospice provider and they certify the patient as terminally ill. The Medicare hospice benefit provides certain hospice services for a patient if the certification and recertification for services meet the required criteria.

**Description:** According to the [2021 Medicare Fee-for-Service Supplemental Improper Payment Data](#) report, the projected improper payment amount for hospice services was \$1.7 billion, resulting in an improper payment rate of 7.8%. Insufficient documentation was the root cause for improper payments and accounted for 65.6% of improper payments made to providers.

**Examples of Improper Payments Due to Insufficient Documentation for Certification of Illness****Example 1**

A hospice provider submits the following documentation they collected to certify their patient terminally ill in response to the CERT Review Contractor request:

- Physician authenticated certification of terminal illness that includes the physician's narrative
- Election of Benefits statement
- Plan of care and physician's orders
- Interdisciplinary group conference notes
- Physician's progress note
- Initial nursing assessment
- Nursing visit notes

**What Documentation Was Missing?**

The certification of terminal illness narrative didn't have an attestation statement.

**What Happens Next?**

The CERT Review Contractor finalizes the claim as an insufficient documentation error, and the MAC recoups payment.

## Example 2

A hospice provider submits the following documentation they collected to certify their patient terminally ill in response to the CERT Review Contractor request:

- Physician authenticated certification of terminal illness for the benefit period that includes the physician's attestation statement
- Election of Benefits statement
- Plan of care and physician's orders
- Decline in clinical status worksheet authenticated by nurse
- Visit notes by nurse, aide, and social worker
- Admission nurse assessment
- Physical therapy evaluation
- Occupational therapy evaluation
- Hospital records

### What Documentation Was Missing?

The certification of terminal illness was missing the physician's brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less.

### What Happens Next?

The CERT Review Contractor finalizes claim as an insufficient documentation error, and the MAC recoups payment.

### Recommendation

- Collect and submit proper documentation when billing for hospice to prevent claim denials and improper payments
- Review the resources below and visit the CERT Provider [webpage](#) for more information

### Resources

- [42 CFR 418.22](#)
- [CMS CERT Program](#)
- [Medicare Benefit Policy Manual, Chapter 9, Section 20.1 – Timing and Content of Certification](#)
- [Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 60 – Certification and Recertification by Physicians for Hospice Care](#)
- [MLN Matters Article – SE1628: Documentation Requirements for the Hospice Physician Certification/Recertification](#)

**COMPREHENSIVE ERROR RATE TESTING (CERT): REFILLS OF DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS) ITEMS PROVIDED ON A RECURRING BASIS****DME PHY NPPs****Provider Types Affected:**

- DMEPOS Suppliers
- Physicians
- Non-Physician Practitioners (NPPs)

**Background:** Medicare covers certain items if it meets the following criteria:

- Eligible for a defined Medicare benefit category
- It's reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Meet all other applicable Medicare statutory and regulatory requirements

Medicare Part B pays for DMEPOS, including ventilators, oxygen equipment and accessories, and blood glucose test strips, if a provider prescribes the item for use in the patient's home or in an institution that's used as a home.

All claims for DMEPOS items billed to Medicare require a written order/prescription from the treating practitioner as a condition for payment. We refer to the written order/prescription as the Standard Written Order (SWO).

**Medicare requires a new order/prescription:**

- For all claims for purchases or initial rentals
- If there's a change in the DMEPOS order/prescription (for example, a change in quantity)
- On a regular basis if it's specified in the documentation section of a medical policy (even if there's no change in the order/prescription)
- To replace an item
- When there's a change in the supplier, and the new supplier is unable to obtain a copy of a valid order/prescription for the DMEPOS item from the transferring supplier

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. Find resources and more from the [CMS Office of Minority Health](#):

- [Health Equity Technical Assistance Program](#)
- [Disparities Impact Statement](#)

Suppliers must contact the patient before dispensing or shipping a refill even if they're refilling a DMEPOS item on a recurring basis. This ensures the refilled item remains reasonable and necessary, patient is low on item supply, and confirms any changes or modifications to the SWO. Suppliers should contact the patient or designee no sooner than 14 calendar days before the shipping date and ensure their patient gets the delivery of refills no sooner than 10 calendar days before the end of usage of the current item.

Suppliers must document a delivery request for refill. Sufficient documentation of a delivery request includes a written document received from the patient or a written record of a phone conversation between the supplier and patient.

For items the patient obtains in-person at a retail store, the signed delivery slip or a copy of the itemized sales receipt is sufficient documentation of a request for refill.

The refill record must include:

- Patient's name or authorized representative.
- A description of each requested item.
- Date of refill request.
- Documentation of quantity remaining for **consumable supplies** patient has remaining before next refill. Consumable supplies include items such as ostomy or urological supplies and surgical dressings. Suppliers must assess supply quantity before refill to make sure remaining supplies will be nearly exhausted on or about the supply anniversary date.
- Documentation of functional condition for **non-consumable supplies** to show the cause of the dysfunction that indicates a replacement (refill). Non-consumable supplies include items such as Positive Airway Pressure (PAP) and Respiratory Assist Devices (RAD). The supplier must assess whether the supplies remain functional, providing replacement (a refill) only when the supply item(s) no longer functions.

### Finding: Insufficient Documentation Causes Improper Payments

According to the [2021 Medicare Fee-for-Service Supplemental Improper Payment Data](#) report, the projected improper payment rate for DMEPOS was 28.6%, accounting for 9.5% of the overall Medicare FFS improper payments. The projected improper amount for DMEPOS during the 2021 reporting period was \$2.4 billion. The majority (76.9%) of the DMEPOS improper payments were due to insufficient documentation. Missing or inadequate refill record attributed to a portion of the DMEPOS insufficient documentation errors.

### Examples of Improper Payments Due to Insufficient Documentation for DMEPOS Refill Record

#### Example 1

A supplier bills for a refill of HCPCS A7034 (mask or cannula type) and submits the following documentation in response to the CERT Review Contractor's request:

- Treating physician's detailed written order
- Physician's visit note
- Sleep study report
- Proof of delivery



**What Documentation Was Missing?**

The supplier didn't include the refill record.

**What Happens Next?**

The CERT Review Contractor finalizes the claim as an insufficient documentation error, and the MAC recoups payment.

**Example 2**

A supplier bills for a refill of HCPCS A4623 (tracheostomy inner cannulas) and submits the following documentation in response to the CERT Review Contractor's request:

- Refill record that's missing the remaining quantity the patient has left of the billed item
- Refill order
- Treating practitioner's clinical record
- Proof of delivery

**What Documentation Was Missing?**

The supplier didn't include the remaining quantity the patient has left of HCPCS A4623 (tracheostomy inner cannulas) in the refill record.

**What Happens Next?**

The CERT Review Contractor finalizes the claim as an insufficient documentation error, and the MAC recoups payment.

**Recommendation**

- Collect and submit all proper documentation for DMEPOS refills to avoid billing errors and improper payments
- Review the resources below and visit the CERT Provider [webpage](#) for more information

**Resources**

- [42 CFR 410.38\(d\)\(1\)](#)
- [Local Coverage Article A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs](#)
- [Medicare Benefit Policy Manual, Chapter 15, Section 110 - Durable Medical Equipment - General](#)
- [Medicare Program Integrity Manual, Chapter 5, Section 5.2 - Rules Concerning DMEPOS Orders/Prescriptions](#)
- [Sections 1861\(s\)\(6\) and 1861\(s\)\(9\) of the Social Security Act](#)

**RECOVERY AUDITOR REVIEW 0184: TOTAL HIP ARTHROPLASTY - MEDICAL NECESSITY AND DOCUMENTATION REQUIREMENTS****Provider Types Affected:**

- Inpatient Hospital
- Outpatient Hospital
- Professional Services

**Problem Description:** Providers should be aware of the documentation and medical necessity criteria when billing for Total Hip Arthroplasty (THA) surgery, also referred to as joint replacement. THA surgery is usually performed for diseases which affect the function of the hip joint (ball (femoral head)). The Recovery Audit Contractor (RAC) reviews the medical record to determine if medical necessity and documentation requirements were met.

**Background:**

The CPT codes for this review are:

- 27130 (Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft)
- 27132 (Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft)
- 27134 (Revision of total hip arthroplasty; both components, with or without autograft or allograft)
- 27137 (Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft)
- 27138 (Revision of total hip arthroplasty; femoral component only, with or without allograft)

**Recommendation**

- Follow documentation and medical necessity guidelines when billing for THA to prevent claim denials and improper payments for THA claims. Review the guidelines in the Local Coverage Determinations (LCDs) and Local Coverage Articles (LCAs) on [your MAC's website](#).
- Respond to review requests promptly and completely, and ensure you include records that demonstrate medical necessity for THA.
- Review the resources below to learn more about documentation and medical necessity requirements when billing for THA.





## Resources

- [First Coast LCD L33618 - Major Joint Replacement \(Hip and Knee\); Effective 10/01/2015; Revised 01/08/2019](#)
- [Medicare Fee for Service Recovery Audit Program](#)
- [NGS LCD L36039 - Total Joint Arthroplasty; Effective 12/01/2015; Revised 10/10/2019](#)
- [Noridian LCA A57684 - Billing and Coding: Total Hip Arthroplasty; Effective 12/01/2019](#)
- [Noridian LCD L36573 - Total Hip Arthroplasty; Effective 09/07/2016; Revised 12/01/2019](#)
- [Novitas LCD L36007 - Lower Extremity Major Joint Replacement \(Hip and Knee\); Effective 10/01/2015; Revised 11/14/2019](#)
- [Palmetto LCA A56777 - Billing and Coding: Total Joint Arthroplasty; Effective 08/01/2019; Revised 10/17/2019](#)
- [Palmetto LCD L33456 - Total Joint Arthroplasty; Effective 10/01/2015; Revised 07/15/2021](#)