

MEDICARE QUARTERLY PROVIDER COMPLIANCE NEWSLETTER

Guidance to Address Billing Errors

Volume 8, Issue 3



PRINT-FRIENDLY VERSION

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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.



Physicians



Non-Physician
Practitioners



Durable Medical
Equipment Suppliers



Skilled Nursing Facility

COMPREHENSIVE ERROR RATE TESTING (CERT): EVALUATION & MANAGEMENT SERVICES**PHY NPP**

Provider Types Affected: Physicians and Non-Physician Practitioners (NPPs) who provide Evaluation & Management (E&M) services and consultations

Background: E&M services are visits and consultations by physicians and other qualified NPPs to Medicare beneficiaries.

The type of service, place of service, patient's status, and content of the service determine the category of E&M service. The key components that determine the correct E&M level are:

- History (includes information such as the nature of presenting problem, past history, family history, social history, and review of systems)
- Physical examination
- Medical decision making (includes such factors as the number of possible diagnoses and management options that must be considered; the amount and complexity of the medical records, diagnostic tests, and other information that must be obtained, reviewed, and analyzed; the risk of significant complications, morbidity, and mortality, the beneficiary's comorbidities that are associated with the presenting problems; and the possible management options)
- Time required to provide the service

Finding: Incorrect Coding and Insufficient Documentation Cause Most Improper Payments

The 2017 improper payment rate for E&M services was 12.1 percent, accounting for 10.6 percent of the overall Medicare FFS improper payment rate.

- Incorrect coding errors occur when the medical records submitted support a different E&M code than the one billed.
- Insufficient documentation errors occur when the medical records submitted were either missing or inadequate to support payment for the billed services. In other words, the CERT Review Contractor could not conclude that the billed services were actually provided, were provided at the level billed, and/or were medically necessary. These errors also occur when a specific documentation element, that is required as a condition of payment, is missing, such as a physician signature on a progress note or a form that is required to be completed in its entirety.
- Another cause for insufficient documentation errors is due to physicians providing services in a setting other than their own office but failing to submit the medical records for the correct setting.

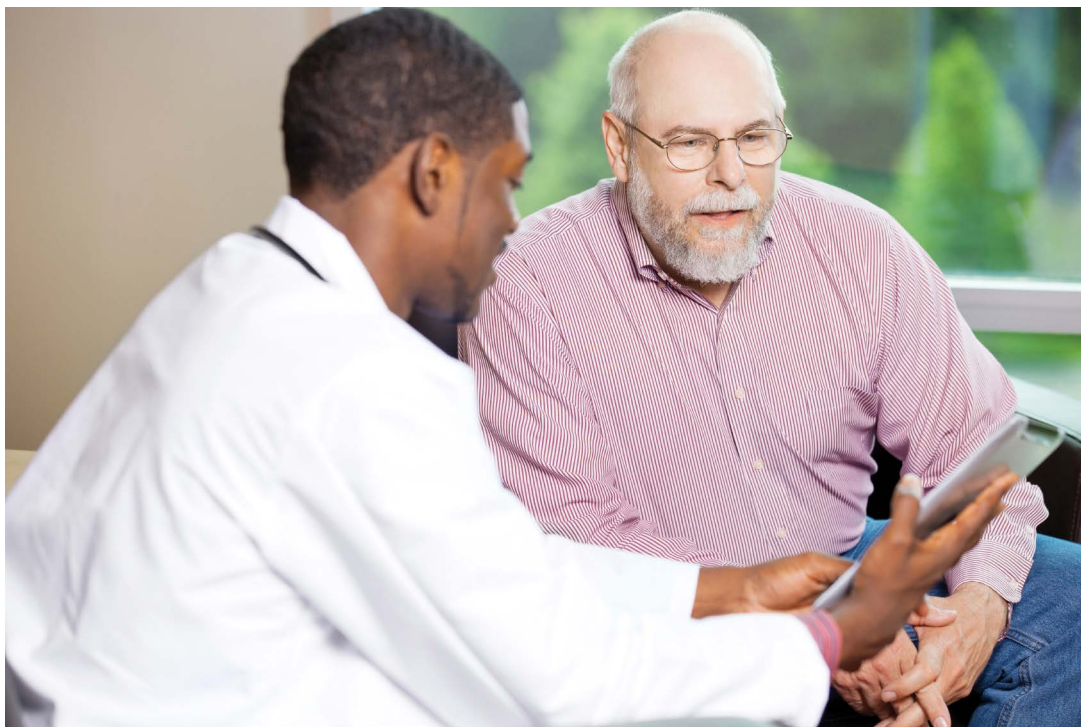
Example of Improper Payments due to Insufficient Documentation

A physician billed an E&M service that was provided in an inpatient setting. The record submitted was a visit note from the physician's office. The documentation did not support the billed E&M code and would be scored as an insufficient documentation error.

Resources:

You can find more information on how to avoid errors on claims for E&M Services at:

- Medicare Claims Processing Manual, Chapter 12, Section 30.6 - Evaluation and Management Service Codes - General (Codes 99201 - 99499), and Chapter 12, Section 100.1.1 - Evaluation and Management (E/M) Services - which are available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>.
- Medicare Learning Network Evaluation and Management Services Guide, ICN 006764, August 2017, which is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf>.



COMPREHENSIVE ERROR RATE TESTING (CERT): VENTILATORS**PHY DMES**

Provider Types Affected: Physicians and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

Background: Ventilators are classified as DMEPOS items. There are two Healthcare Common Procedure Coding System (HCPCS) codes that providers can use to submit claims, E0465 and E0466. The description for each HCPCS code is as follows:

- **E0465** - Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)
- **E0466** - Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)

The Medicare National Coverage Determinations (NCD) Manual, [Section 280.1](#) - Durable Medical Equipment Reference List, stipulates that HCPCS codes E0465 and E0466 are covered for the treatment of beneficiaries with one of the following medical conditions:

- Neuromuscular diseases
- Thoracic restrictive diseases
- Chronic respiratory failure consequent to chronic obstructive pulmonary disease

Finding: Medical Necessity Causes Most Improper Payments

For the 2017 CERT report period, the improper payment rate for ventilators was 57.4 percent, accounting for 0.5 percent of the overall Medicare Fee-for-Service (FFS) improper payments.

Medical necessity errors for ventilators accounted for 58 percent of improper payments. The provider's documentation failed to indicate that the billed ventilator was used for the treatment of at least one of the three medical conditions listed in [NCD 280.1](#).



Example of Improper Payment due to Medical Necessity - Missing documentation to support medical necessity

A DMEPOS supplier billed for HCPCS code E0465 and submitted the following:

- A signed order
- A sleep oximetry test report
- A signed progress note indicating the beneficiary is being treated for sleep apnea

An additional request for documentation returned no documentation. The submitted progress note states that the beneficiary has obstructive sleep apnea. There is no documentation to support that the ventilator is being used to treat the beneficiary for one of the three covered medical conditions per NCD 280.1. The CERT review contractor scored this claim as a medical necessity error and the Medicare Administrative Contractor recovered the payment from the provider.

Resources:

You may want to review the following information to help avoid medical necessity errors:

- The 2017 Medicare FFS Supplemental Improper Payment Data Report, which is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2017-Medicare-FFS-Improper-Payment.pdf>.
- Information regarding “reasonable and necessary” criteria based on Social Security Act, Section 1862(a)(1)(A) provisions, which are available at https://www.ssa.gov/OP_Home/ssact/title18/1862.htm.
- The NCD Manual, Chapter 1, Part 4, Section 280.1 stipulates that ventilators are covered for 3 medical conditions. This manual section is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.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/>.

RECOVERY AUDITOR FINDING: DURABLE MEDICAL EQUIPMENT (DME) SUPPLIERS BILLING FOR DME FOR BENEFICIARIES IN A MEDICARE INPATIENT STAY

DMES SNF

Provider Types Affected: Suppliers and physicians furnishing DME to patients in an inpatient facility (hospital or skilled nursing facility (SNF))

Problem Description: A supplier (includes physician furnishing DME) may deliver a DME, prosthetics, or orthotics (DMEPOS) item to a patient in a hospital or SNF for the purpose of fitting or training the patient in the proper use of the item. This may be done up to 2 days prior to the patient's anticipated discharge to their home. The supplier should bill the date of service on the claim as the date of discharge and shall use the place of service (POS) as 12 (patient's home). The item must be for subsequent use in the patient's home. No billing may be made for the item on those days the patient was receiving training or fitting in the hospital or nursing facility.

Medicare Policy: Medicare policy regarding billing for such DMEPOS items is available in the Medicare Claims Processing Manual, [Chapter 20](#), Sections 110.3, 211, and 212. Specific policy related to pre-discharge delivery of DMEPOS is that Medicare will presume that the pre-discharge delivery of DME, a prosthetic, or an orthotic (hereafter "item") is appropriate when all the following conditions are met:

1. The item is medically necessary for use by the beneficiary in the beneficiary's home.
2. The item is medically necessary on the date of discharge, for example, there is a physician's order with a stated initial date of need that is no later than the date of discharge for home use.
3. The supplier delivers the item to the beneficiary in the facility solely for the purpose of fitting the beneficiary for the item, or training the beneficiary in the use of the item, and the item is for subsequent use in the beneficiary's home.
4. The supplier delivers the item to the beneficiary no earlier than 2 days before the day the facility discharges the beneficiary.
5. The supplier ensures that the beneficiary takes the item home, or the supplier picks up the item at the facility and delivers it to the beneficiary's home on the date of discharge.
6. The reason the supplier furnishes the item is not for the purpose of eliminating the facility's responsibility to provide an item that is medically necessary for the beneficiary's use or treatment while the beneficiary is in the facility. Such items are included in the Diagnostic Related Group (DRG) or Prospective Payment System (PPS) rates.
7. The supplier does not claim payment for the item for any day prior to the date of discharge.



8. The supplier does not claim payment for additional costs that the supplier incurs in ensuring that the item is delivered to the beneficiary's home on the date of discharge. The supplier cannot bill the beneficiary for redelivery.
9. The beneficiary's discharge must be to a qualified place of service (such as home, custodial facility), but not to another facility (inpatient or skilled nursing) that does not qualify as the beneficiary's home.

Finding: The Recovery Auditor performed an automated review of selected claims from the last 3 years in which DMEPOS was billed. The specific HCPCS codes reviewed were E0100 - E8002, K0001 – K0899, L0112 – L4631, V2020 – V2786, A4206 – A9999, B4034 – B9999, and relevant J and Q codes. In addition to looking at such DMEPOS claims, the Recovery Auditor looked for Types of Bills 011X, 012X, 018X, 021X, or 022X, which would show a beneficiary inpatient stay for the date of service on the DMEPOS claim. The Recovery Auditor did identify claims for such codes with a date of service that fell during a covered inpatient or SNF stay. Thus, suppliers should remember the rules for providing DMEPOS items to a beneficiary during a stay that is covered by a DRG or PPS payment as noted above and in the Medicare Claims Processing Manual, Chapter 20, Section 110.3.

Resources:

You may want to review the following information to help avoid medical necessity errors:

- The Medicare Claims Processing Manual, Chapter 20, Section 110.3, which is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf>.



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