MEDICARE QUARTERLY PROVIDER COMPLIANCE NEWSLETTER

Guidance to Address Billing Errors

Volume 9, Issue 4

PRINT-FRIENDLY VERSION

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Archive of previous Medicare Quarterly Provider Compliance Newsletters

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

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 (RACs) 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 Centers for Medicare & Medicaid Services (CMS) releases the newsletter on a quarterly basis. An archive of previously-issued newsletters, which includes keyword and provider-specific indices, is available on the CMS website.

Non-Physician Practitioners

Durable Medical Equipment Suppliers

Physicians

Hospitals

Doctors of Chiropractic

COMPREHENSIVE ERROR RATE TESTING (CERT): NEGATIVE PRESSURE WOUND THERAPY (NPWT) FOR THE TREATMENT OF WOUNDS

PHY NPP DMES

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

Background: NPWT is the application of sub-atmospheric pressure to a wound to remove exudate and debris from wounds. NPWT is delivered through an integrated system consisting of a suction pump, separate exudate collection chamber, and dressing sets to a qualified wound. In these systems, exudate is completely removed from the wound site to the collection chamber. Medicare covers NPWT equipment under the DME benefit (Social Security Act §1861(s)(6)).

Medicare covers a NPWT pump and supplies in the following scenarios:

Within the Home Setting:

- When the beneficiary has a chronic Stage III or IV pressure ulcer, neuropathic (for example, diabetic) ulcer, venous or arterial insufficiency ulcer, or a chronic (being present for at least 30 days) ulcer of mixed etiology.

Encountered in an Inpatient Setting:

- The beneficiary has an ulcer or wound as described above in the home setting section, and, after wound treatments (described within applicable Local Coverage Determination (LCD) based on the type of ulcer or wound) have been tried or considered and ruled out. NPWT is initiated because it is considered, in the judgment of the treating physician/NPP, to be the best available treatment option.
- The beneficiary has complications of a surgically created wound (for example, dehiscence) or a traumatic wound (for example, pre-operative flap or graft) where there is documentation of the medical necessity for accelerated formation of granulation tissue which cannot be achieved by other available wound treatments.

Medicare will deny claims for a NPWT pump and supplies as not reasonable and necessary whenever one or more of the following are present:

- Necrotic tissue with eschar, if debridement is not attempted
- Osteomyelitis within the wound that is not concurrently being treated
- Cancer present in the wound
- The presence of an open fistula to an organ or body cavity within the vicinity of the wound.

For all ulcers or wounds, a complete wound therapy program, as applicable depending on the type of wound, must have been tried or considered and ruled out prior to the application of NPWT. The following are general components of a wound therapy program, for all ulcers and wounds, which providers must document in the medical record:

- Evaluation, care, and wound measurements by a licensed medical professional
- Application of dressings to maintain a moist wound environment
- Debridement of necrotic tissue if present
- Evaluation of and provision for adequate nutritional status

Finding: Insufficient Documentation Causes Improper Payments

For the 2018 CERT report period, the improper payment rate for NPWT was 32.8 percent, accounting for 0.1 percent of the overall Medicare Fee-for-Service improper payment rate. The projected improper payment amount for NPWT during the 2018 report period was $24.4 million. The majority of improper payments for NPWT claims were due to insufficient documentation, which means that something was missing from the submitted medical records to support payments for the item(s) billed. Those claims with insufficient documentation, based on Medicare guidelines, lacked one or more of the following:

- A valid physician or NPP's order that includes all elements required by regulation, Medicare program manuals, and Medicare Administrative Contractor (MAC) specific guidelines
- Documentation of a wound therapy program containing all minimum components as required per the LCD and Local Coverage Article

Example of Improper Payments due to Insufficient Documentation – Missing or inadequate order

On the 5th month of rental, a supplier billed for HCPCS Code E2402 (Negative pressure wound therapy electrical pump, stationary or portable) and in response to the CERT review contractor's request for documentation, the supplier submitted the following:

- Detailed written order with 4 months length of need
- Proof of delivery
- Physician's clinical records documenting beneficiary with Stage IV hip wound, active infection that is being treated with antibiotics, who received surgical debridement and the application of NPWT
- Nursing progress notes documenting wound measurements

An additional request for documentation returned no documentation. There was no detailed written order for the billed date of service (the fifth month rental) as Medicare policy requires. The CERT review contractor scored this claim as an insufficient documentation error and the MAC recouped payment from the provider.

Example of Improper Payments due to Insufficient Documentation – Missing complete wound therapy program documentation

A supplier billed for HCPCS Code E2402 (Negative pressure wound therapy electrical pump, stationary or portable) and in response to the CERT review contractor's request for documentation, submitted the following:

- Detailed written order
- Proof of delivery
- Physician's clinical records documenting the beneficiary has diabetes, a heel ulcer with pain, is bed to chair bound, and receiving antibiotic treatments with no mention of nutritional status
- Operative note documenting excisional debridement

An additional request for documentation returned physician visit notes documenting wound measurements and continued NPWT treatment. There was no documentation of nutritional status prior to application of NPWT as Medicare policy required. The CERT review contractor scored this claim as an insufficient documentation error and the MAC recouped payment from the provider.

Example of Improper Payments due to Insufficient Documentation – Missing complete wound therapy documentation

A supplier billed for HCPCS code E2402 (Negative pressure wound therapy electrical pump, stationary or portable) and in response to the CERT review contractor's request for documentation, submitted the following:

- Detailed written order
- Proof of delivery
- Occupational Therapy/Physical Therapy notes documenting Mobility Related Activities of Daily Living training and nutritional assessment
- Treating physician's clinical records documenting the diagnoses of cellulitis, Type 2 diabetes, and asthma
- Physician's consultation note that includes an initial evaluation of the wound including measurements; however the wound depth, amount of drainage, and condition of the wound were missing

An additional request for documentation returned no documentation. The documentation the supplier submitted was missing the complete evaluation of the wound, including the condition of the wound, wound depth, and amount of drainage prior to the application of NPWT as Medicare policy required. The CERT review contractor scored this claim as an insufficient documentation error and the MAC recouped payment from the provider.

Resources:

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

- Section 1833 (e) (Insufficient Documentation) of the Social Security Act, which is available at https://www.ssa.gov/OP_Home/ssact/title18/1833.htm
- Section 1862 (a) (1) (A) (Exclusions from coverage and Medicare as Secondary Payer) of the Social Security Act, which is available at https://www.ssa.gov/OP_Home/ssact/title18/1862.htm
- Section 1861 (s)(6) of the Social Security Act, which is available at https://www.ssa.gov/OP_Home/ssact/title18/1861.htm
- The Medicare Benefit Policy Manual, Chapter 7, Section 40.1.2.8 – Covered Services Under a Qualifying Home Health Plan of Care, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf
- The Medicare Benefit Policy Manual, Chapter 14, Section 10 – Coverage of Medical Devices which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c14.pdf
- The Medicare Claims Processing Manual, Chapter 10, Section 90.3 – Billing Instructions for Disposable Negative Pressure Wound Therapy Services, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf
- Local Coverage Determinations for Negative Pressure Wound Therapy https://www.cms.gov/medicare-coverage-database/
- Local Coverage Article for Negative Pressure Wound Therapy https://www.cms.gov/medicare-coverage-database/
- The CERT provider website at https://certprovider.admedcorp.com/
- The CERT program website at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/index.html

COMPREHENSIVE ERROR RATE TESTING (CERT): REMINDER ON PROPER DOCUMENTATION FOR CHIROPRACTIC SERVICES

PHY DC

Provider Types Affected: Physicians and Doctors of Chiropractic

Background: 2018 Medicare Fee-for-Service Supplemental Improper Payment Data (CERT Report) reported a 41 percent improper payment rate on claims for chiropractic services on part B claims. Of those errors, 88.3 percent were due to insufficient documentation. This places Chiropractic treatment in the top 20 service types with highest improper payment rates. Chiropractic Services also has a 1.2 percent improper payment rate in the report for upcoding errors. Upcoding refers to billing a higher level service or a service with a higher payment than is supported by the medical record documentation.

Problem Description: The majority of chiropractic services claims errors in this review were the result of insufficient documentation. Note that the Medicare Fee-for-Service 2018 Improper Payment Rate Report's finding that insufficient medical record documentation was the most common reason (88%) for improper chiropractic payment. See "The Supplementary Appendices for the Medicare Fee-for-Service 2018 Improper Payment Rate Report," at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2018MedicareFFSSuplementalImproperPaymentData.pdf.

Medicare limits coverage of chiropractic services to treatment by means of manual manipulation (that is, by use of the hands) of the spine to correct a subluxation. The patient must require treatment by means of manual manipulation of the spine to correct a subluxation, and the manipulative services the Doctor of Chiropractic provides must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. The Doctor of Chiropractic may use manual devices (that is, those that are hand-held with the thrust of the force of the device being controlled manually) in performing manual manipulation of the spine. However, Medicare makes no additional payment for use of the device, nor does Medicare recognize an extra charge for the device itself.

Doctors of Chiropractic are limited to billing three Current Procedural Terminology (CPT) codes under Medicare: 98940 (chiropractic manipulative treatment; spinal, one to two regions), 98941 (three to four regions), and 98942 (five regions). When submitting manipulation claims, Doctors of Chiropractic must use an Acute Treatment (AT) modifier to identify services that are active, corrective treatment of an acute or chronic subluxation. The AT modifier, when used appropriately, should indicate expectation of functional improvement, regardless of the chronic nature or redundancy of the problem.

Guidance on How Providers Can Avoid These Problems

There are specific documentation requirements for the initial and subsequent chiropractic patient visits. The Medicare Benefit Policy Manual, Chapter 15, Section 240, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf, describes medical record documentation requirements of chiropractic services.

For the initial chiropractic visit, the documentation must include the following information:

- Patient history
- Description of present illness and evaluation of musculoskeletal/nervous system through physical examination
- Diagnosis (primary diagnosis must be subluxation)
- Treatment plan
- Date of initial treatment

The physical examination must demonstrate at least two of the four following criteria; (1) pain, tenderness; (2) asymmetry, misalignment; (3) abnormal range of motion; and (4) tissue, tone changes. One of these criteria must be either asymmetry, misalignment, or abnormal range of motion.

For each subsequent visit, the documentation requirements must include all components listed below:

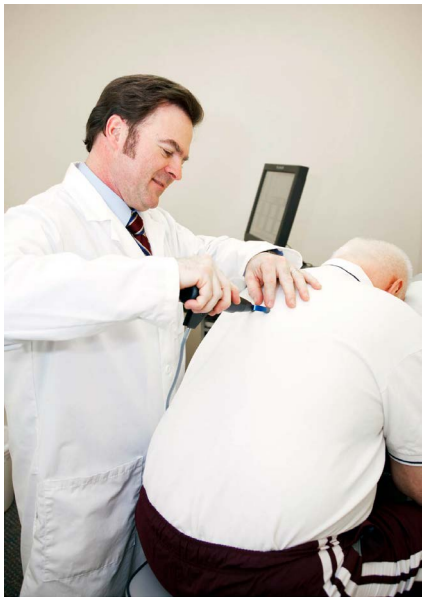
- Patient history (lists such items as changes since last visit)
- Physical examination
- Documentation of treatment provided at each visit.

CMS suggests that providers keep the following documentation practices in mind:

- **Signature requirements** - Medical record documentation must be authenticated by the author's legible signature. Please refer to the national provider signature requirements published in the "Medicare Program Integrity Manual," Chapter 3, Section 3.3.2.4, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf.
- **Documenting Procedures** - Document procedures as soon as possible after performing them, and include the code that best corresponds to the service provided.
- **Self Audit** - A helpful technique for assuring good documentation is to periodically self-audit claims against records to determine if the records support the chosen codes. Auditing and correcting non-conforming office practices help minimize claim errors that occur with the clerical task of preparing and submitting the claim. It is also helpful for providers who use devices to assist manipulations to clearly document the name of the device, and, if necessary, send with the records submitted to auditors, a device description or other information describing how the device meets CMS requirements for assistive devices.
- **Medical Necessity** - Thorough documentation of clinically relevant and CMS required documentation elements serve to create a clear picture of the patient's baseline condition, treatments provided, and a treatment timeline in terms of the patient's symptomatic functional response.

Documentation of the initial evaluation and of periodic reevaluations at reasonable intervals is essential.

- During the initial evaluation, describe the patient's presenting condition (symptoms, physical signs, and function) in objective, measurable terms along with pertinent subjective information. Provide a clear description of the mechanism of injury and how it negatively impacts baseline function. A clear plan of treatment should include treatment goals, expected duration and frequency, and the clinical milestones to be used as measures of progress.
- When documenting the periodic reevaluations, you should demonstrate the patient's progress in objective terms. The evaluation elements need not be documented at each treatment; however, they must be present often enough to show measurable progress, or failure to progress. Medicare encourages Doctors of Chiropractic to include all pertinent, clinical information to support the need for care when submitting documentation to Medicare auditors.



Doctors of Chiropractic should be afforded the opportunity to effect improvement or arrest or retard deterioration in such condition within a reasonable and generally predictable period of time, but maintenance care is not covered by Medicare. (See the Medicare Benefit Policy Manual, Chapter 15, Sections 240.1.3 and 240.1.5.)

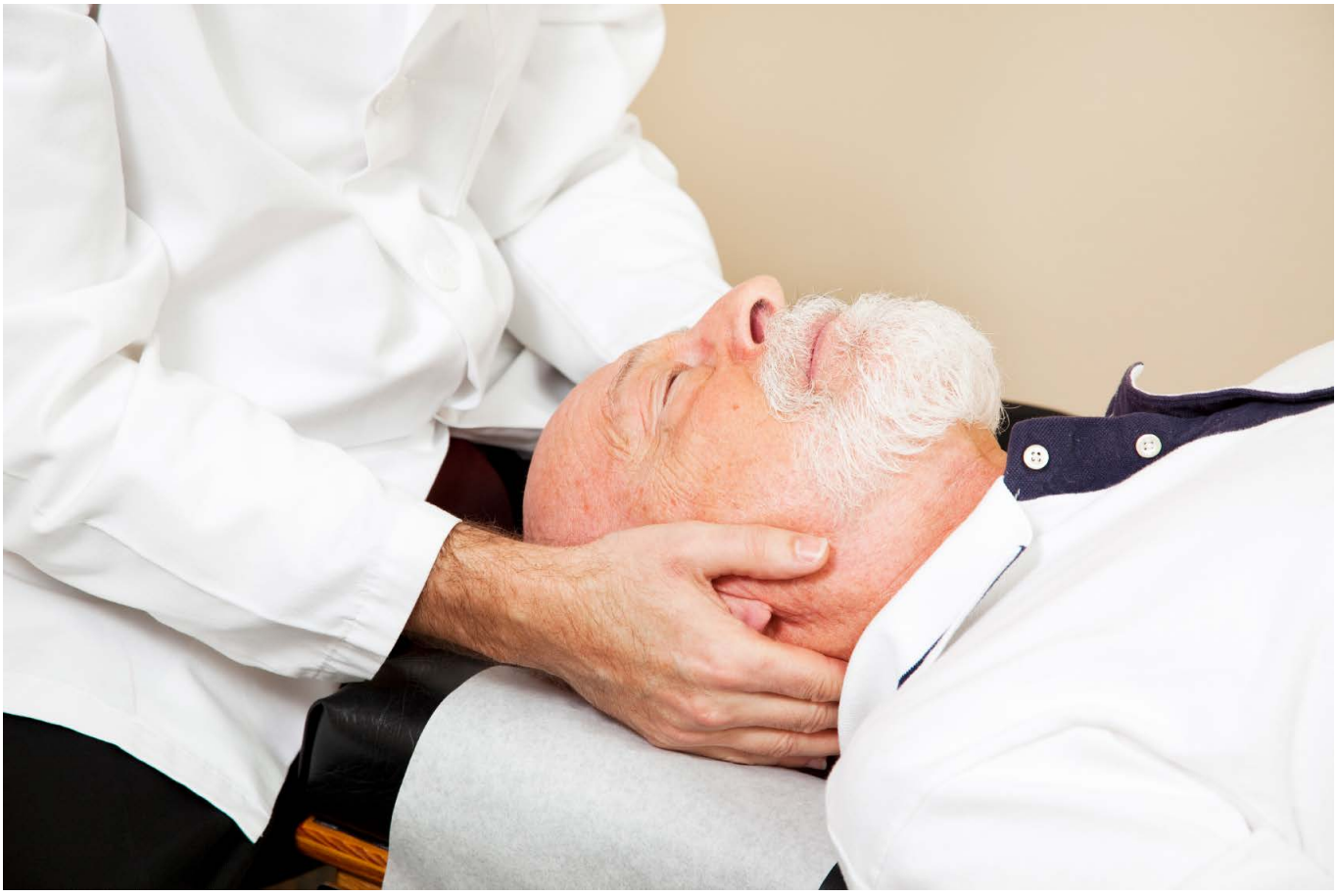
CMS has released a Medicare Documentation Job Aid, put together by the MACs for Doctors of Chiropractic. This job aid provides guidance about what documentation to include with a request for medical records and is useful for avoiding documentation errors including insufficient documentation.

Resources:

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

- Article SE1101 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1101.pdf provides an overview of Medicare covered chiropractic services.
- The Medicare Benefit Policy Manual, Chapter 15, Section 240 is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf.
- A new Medicare Learning Network Educational Tool, Medicare Documentation Job Aid for Doctors of Chiropractic, is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-PublicationsItems/MLN1232664.html.
- The CERT 2018 Medicare Fee-For-Service Supplemental Improper Payment Data report is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2018MedicareFFSSuplementalImproperPaymentData.pdf
- MLN Matters article SE1601, which is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se1601.pdf discusses medical record documentation requirements for chiropractic services.

- SE1602, which is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se1602.pdf discusses the use of the AT modifier.
- SE1603 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se1603.pdf lists a wide array of materials to assist doctors of chiropractic in delivering covered services to Medicare beneficiaries and correctly billing for those services.
- Article MM3449, Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR3063 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm3449.pdf.
- Article SE0749, Addressing Misinformation Regarding Chiropractic Services and Medicare, is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE0749.pdf.



RECOVERY AUDITOR (RAC) FINDING: EVALUATION AND MANAGEMENT SERVICES FOR OFFICE OR OTHER OUTPATIENT VISIT BILLED FOR HOSPITAL INPATIENTS: INCORRECT CODING

PHY NPP

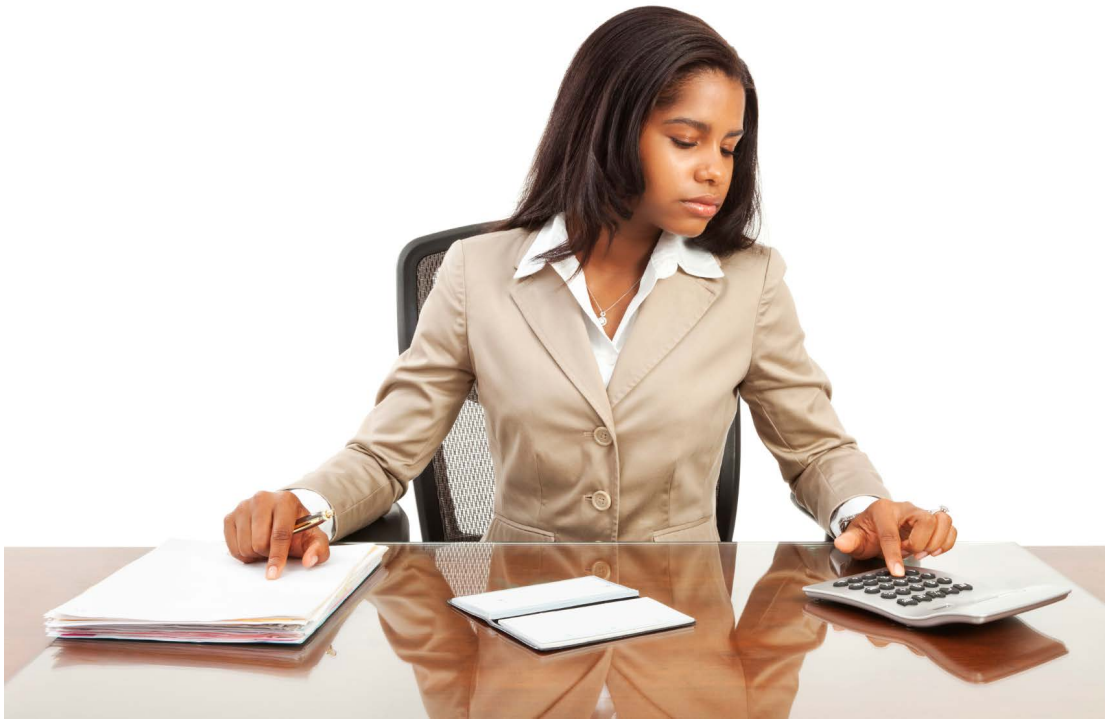
Provider Types Affected: Professional Services (Physicians, and Non-Physician Practitioners (NPPs))

Finding: Recovery Auditors (RACs) are finding that office or other outpatient visits for evaluation and management services are being billed for patients admitted to a hospital setting. CPT codes 99201-99215 are to be used for evaluation and management services provided in the physician's office, or in an outpatient or other ambulatory facility.

Resources:

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

- Medicare Claims Processing Manual, Chapter 12, Sections 30.6, 30.6.9.1 and 30.6.10, Evaluation and Management Coding which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
- Social Security Act, Section 1833 (e) which is available at https://www.ssa.gov/OP_Home/ssact/title18/1833.htm



RECOVERY AUDITOR (RAC) FINDING: SPINAL ORTHOSES (LUMBAR SACRAL ORTHOSES (LSO) AND THORACIC LUMBAR SACRAL ORTHOSES (TLSO)) WITHIN THE REASONABLE USEFUL LIFETIME (RUL)

DMES NPP PHY

Provider Types Affected: Durable Medical Equipment (DME) Suppliers and Physicians or Non-Physician Practitioners (NPPs) who supply DME, specifically Spinal Orthosis.

Background: Lumbar Sacral Orthoses (LSO) and Thoracic Lumbar Sacral Orthoses (TLSO) are covered under the Medicare Braces Benefit (Social Security Act §1861(s) (9)). For coverage under this benefit, the orthosis must be a rigid or semi-rigid device, which is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. Items that are not sufficiently rigid to be capable of providing the necessary immobilization or support to the body part for which it is designed do not meet the statutory definition of the Braces Benefit. Items that do not meet the definition of a brace are statutorily noncovered, no benefit.

Finding: Recovery Auditors (RACs) examined claims for codes L0627, L0631, L0637, L0642, L0648, and L0650. They found claims for more than one spinal orthosis within the reasonable useful lifetime and Medicare will deny such claims.

Resources:

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

- Medicare Benefit Policy Manual, Chapter 15, Section 110.2.C DME Repairs, Maintenance, Replacement, and Delivery which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
- Medicare Program Integrity Manual, Chapter 4 – Program Integrity, Section 4.26 Supplier Proof of Delivery Documentation Requirements which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c04.pdf
- Local Coverage Article: Spinal Orthoses: TLSO and LSO – Policy Article (A52500) available at https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52500&ver=17&LCDId=33790
- Search for Local Coverage Determinations and Local Coverage Articles by your MAC for Spinal Orthosis in the Medicare Coverage Database at https://www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx