MEDICARE QUARTERLY PROVIDER COMPLIANCE NEWSLETTER

Guidance to Address Billing Errors

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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 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.

RECOVERY AUDITOR FINDING: NEW ISSUE #0099 – SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING: OUTPATIENT FACILITY – NOT SEPARATELY PAYABLE SERVICES: UNBUNDLING

Provider Types Affected: Hospital Outpatient Facilities

The SNF annual update file contains a comprehensive list of HCPCS codes involved in editing institutional claims submitted to A/B MACs for services subject to SNF Consolidated Billing (CB). CMS has divided these codes into 5 Major Categories. The 5 categories and spreadsheet with the list of codes are available at https://www.cms.gov/medicare/snf-consolidated-billing/2020-part-mac-update.

Payment for these SNF services provided to beneficiaries by an outpatient facility, during a Medicare Part A SNF stay, are included in a bundled prospective payment and are not separately payable.

In this automated review, the Recovery Auditor Contractors (RACs) identify claims with codes in Major Category I.F. and Major Category 5.A. Codes in Major Category 1.F and 5.A are included in SNF CB. Billing these codes separately during a SNF stay will be identified as overpayments.
Finding: The RACs identify payment for services provided to beneficiaries while they were in a SNF Part A stay. These services are included in a bundled prospective payment and are not separately payable.

The RACs determined these were improper payments and submitted the claims to the appropriate MAC for adjustment.

Resources

You may want to review the following information to learn more about this topic and to help avoid these billing errors:

- Section 1862(a)(1)(A) of the Social Security Act, which is available at https://www.ssa.gov/OP_Home/ssact/title18/1862.htm
- Section 1861(s)(2)(F) of the Social Security Act, which is at https://www.ssa.gov/OP_Home/ssact/title18/1861.htm
- Section 1833(e) of the Social Security Act, which is at https://www.ssa.gov/OP_Home/ssact/title18/1833.htm
- Medicare Claims Processing Manual, Chapter 6 – SNF Inpatient Part A Billing and SNF Consolidated Billing; https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf
- CMS SNF Consolidated Billing https://www.cms.gov/medicare/snf-consolidated-billing/2020-part-mac-update
- MLN Matters Article SE0432, Skilled Nursing Facility Consolidated Billing as It Relates to Certain Types of Exceptionally Intensive Outpatient Hospital Services, https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0432.pdf
- CMS Skilled Nursing Facility PPS Best Practices Guidelines, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/BestPractices
- CMS Skilled Nursing Facility PPS, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/ConsolidatedBilling
- Your MAC(s) website, which you may find at http://go.cms.gov/MAC-website-list.
- Medicare Fee for Service Recovery Audit Program, https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program

RECOVERY AUDITOR FINDING – NEW ISSUE #0129 – HYPERBARIC OXYGEN THERAPY FOR DIABETIC WOUNDS: MEDICAL NECESSITY AND DOCUMENTATION REQUIREMENTS

Provider Types Affected: Hospital Outpatient Facilities

Problem Description: In this complex review, the RACs request documentation from the provider to review outpatient claims for hyperbaric oxygen therapy for diabetic wounds of the lower extremities. Review of medical records seeks to identify documentation to support the indications of coverage outlined in NCD 20.29.

Background: The risk for improper payments (overpayments) exists when claims are paid by Medicare despite insufficient or lacking documentation and/or evidence of medical necessity.

HBO is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure. The beneficiary is entirely enclosed in a pressure chamber breathing 100-percent oxygen at greater than one atmosphere pressure. HBO coverage is governed by guidelines in Chapter 1, Part, 1, Section 20.29 of the Medicare National Coverage Determinations (NCD) Manual.

The use of HBO for diabetic wounds of the lower extremities is covered as adjunctive therapy only after there are no measurable signs of healing for at least 30 days of treatment with standard wound therapy and must be used in addition to standard wound care. Per NCD 20.29 requirements, the medical record must support the following three (3) criteria for coverage:

1. Patient has type I or II diabetes and has a lower extremity wound that is due to diabetes;
2. Patient has a wound classified as Wagner grade III or higher; and
3. Patient has failed an adequate course of standard wound therapy.

Providers should note that under Section 1862(a)(1)(A) of the Social Security Act, “No payment may be made under Part A or Part B for any expenses incurred for items or services not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

Finding: In this complex review, the RACs requested documentation for review. The RACs identified numerous claims for which documentation was received from the provider, but such documentation did not support the medical necessity for HBO. In these cases, the RACs determined these were improper payments and submitted the claims to the appropriate MAC for adjustment.

Recommendations: Providers should review the indications for coverage for hyperbaric oxygen therapy for diabetic wounds of the lower extremities to ensure that their documentation is detailed and sufficient to meet requirements.

Resources

Providers should review the following educational materials to learn more about HBO and to assist in correctly documenting claims featuring HBO therapy.

- **MLN Matters Articles:**
  - **MM3172:** Billing Requirements for Hyperbaric Oxygen Therapy for the Treatment of Diabetic Wounds of the Lower Extremities (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm3172.pdf.)
    - Explains Medicare coverage guidelines, situations where types of HBO are not covered, and provides links to other HBO therapy articles for review.
  - **MM9205:** July 2015 Update of the Hospital Outpatient Prospective Payment System (OPPS) (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm9205.pdf.)
    - This article provided guidance on using HCPCS code G0277 on HBO claims, including what time details may be included and how those are broken down into units for use with G0277. This article also provides a coding example.
  - **SE1113:** Foot Care Coverage Guidelines (2011)
    - On Page 4, the section titled, HBO Therapy for Hypoxic Wounds and Diabetic Wounds of the Lower Extremities (CAG-00060N) provides information related to this RAC topic. (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1113.pdf.)
- **Internet-Only Manuals:**
  - **Medicare NCD Manual**
    - Chapter 1, Part 1, Section 20.29 – Hyperbaric Oxygen Therapy
      - Provides full explanations and rules regarding Medicare's HBO coverage. (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part1.pdf.)
  - **Medicare Claims Processing Manual**
    - Chapter 32, Section 30.1 – Billing Requirements for HBO Therapy for the Treatment of Diabetic Wounds of the Lower Extremities (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c32.pdf.)
- Your MAC(s) website, which you may find at http://go.cms.gov/MAC-website-list.
- Medicare Fee for Service Recovery Audit Program, https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program

RECOVERY AUDITOR FINDING: NEW ISSUE #0103 – UROLOGICAL SUPPLIES: MEDICAL NECESSITY AND DOCUMENTATION REQUIREMENTS

Provider Types Affected: Durable Medical Equipment (DME) Suppliers

Background: Urological supplies are covered under the Prosthetic Device benefit (Social Security Act 1861§(s)(8)). In order for a beneficiary's equipment to be eligible for reimbursement, the equipment/ supplies must meet Reasonable and Necessary (R&N) requirements set out in Local Coverage Determination (LCD) L33803.

For Medicare to cover any item it must:

1. Be eligible for a defined Medicare benefit category
2. Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
3. Meet all other applicable Medicare statutory and regulatory requirements.

For this complex review, the RACs requested documentation to review whether the indications for coverage and documentation requirements were met for the following:

- Indwelling Catheters (HCPCS Codes A4311, A4312, A4313, A4314, A4315, A4316, A4338, A4340, A4344, and A4346)
- Urinary Drainage Collection System (A4314, A4315, A4316, A4354, A4357, A4358, A5102, and A5112)
- Intermittent Irrigation of Indwelling Catheters
- Continuous Irrigation of Indwelling Catheters Intermittent Catheterization (A4351, A4352)

General Policy Guides for Suppliers
From Local coverage Article A55426–
Many errors reported in Medicare audits are due to claims submitted with incomplete or missing requisite documentation. Consequently, the Durable Medical Equipment Medicare Administrative Contracts (DME MACs) have created guidance to assist Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers in understanding the information necessary to justify payment.

The documentation requirements are compiled from Statutes, Code of Federal Regulations, Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCDs), CMS rulings and sub-regulatory guidance (CMS manuals), and DME MAC publications. This article sets out the general requirements that are applicable to all DMEPOS claims submitted to the DME MACs.
Documentation must be maintained in the supplier's files for seven (7) years from date of service (DOS).

All Policy Specific Documentation Requirements are located in the LCD-related Policy Article, which is linked to the applicable LCD.

It is important that suppliers review the actual LCD, the related Policy Article, and the Standard Documentation Requirements (SDR) article to be sure to have all of the relevant information necessary and applicable to the item(s) provided.

Findings: In this complex review, the RACs requested documentation for review. The RACs identified numerous claims for which documentation was received from the supplier, but such documentation did not support the medical necessity for urological supplies. In these cases, the auditors determined these were improper payments and submitted the claims to the appropriate MAC for adjustment.

Resources

Suppliers should review the following educational materials to learn more about urological supplies and to assist in correctly documenting claims featuring urological supplies:

- Local Coverage Article A55426, which is available at https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=55426
- Local Coverage article A52521, which is available at https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52521
- Local Coverage Determination L33803, which is at https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33803
- The Medicare Program Integrity Manual, Chapter 5, Section 5.8, which is at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c05.pdf
- The Medicare Claims Processing Manual, Chapter 20, Sections 30.9, and 130.1, which is at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf
- The Medicare Program Integrity Manual, Chapter 4, Section 4.26.2, which is at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c04.pdf
- Your MAC(s) website, which you may find at http://go.cms.gov/MAC-website-list.
- Medicare Fee for Service Recovery Audit Program, https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program