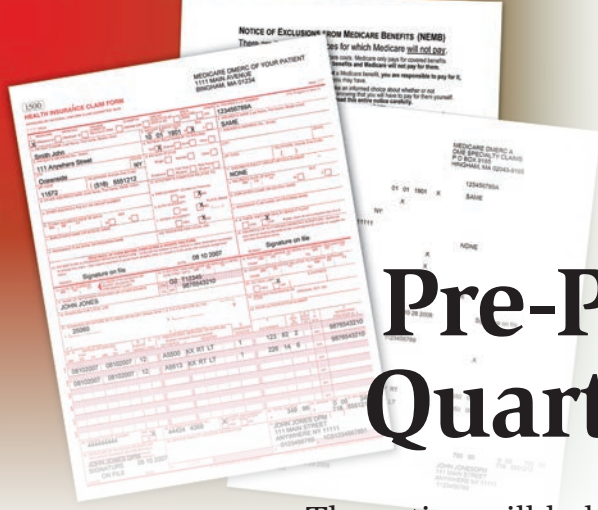

Pre-Pay Review Quarterly Status

These tips will help your claim avoid being rejected.

BY PAUL KESSELMAN, DPM

Each quarter the DME MAC issues an update on the results of their pre-payment review of random claims. Recently, the DME MAC B/C issued their second quarter Pre-Payment Review Quarterly Status Results from a selection of DMEPOS often provided by podiatric physicians. While these results are not specific to podiatrists, the resulting statistics, if interpreted properly, can be useful to a practice compliance program.

AFO Pre-Payment Quarterly Review DME MAC B and C reviewed claims for April 1, 2022 through June 30, 2022 for HCPCS codes: L1902, L1906, L1971, L4361, L4396, and L4397. The error rates for Region B are found in Table 1A, and Region C in Table.1B. Note that for all tables included in this article, multiple error rates are noted for some claims, and the percentages may be greater than 100%.

Explanation and curative measures for these error rates are as follows:

1) Be sure that the HCPCS code on the proof of delivery, and the description of the product in dispensing note and claim are all consistent. This often happens when the description of the product and the written proof of delivery do not match.

2) In order to circumvent same or similar regulations, many providers stipulate that a device was lost or stolen. One must provide the dates that these events occurred and, if possible, provide a police report or report filed by the patient with his/her property insurance carrier.

3) If the medical records do not provide sufficient information on the patient's condition to warrant medical necessity for a specific device, the auditor will fail the claim. This often happens when the prescriber offers a diagnosis without a proper work-up to prove the diagnosis and/or how the prescribed device will benefit the patient. For example, in the case of an ankle brace, simply mentioning a painful sprained ankle without noting how the ankle brace will stabilize the foot/ankle allowing it to heal, will often result in the claim being denied.

4) Most AFOs are used to stabilize patients during ambulation. However, failure to document how

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Rank	Reason	Percent
1.	The documentation does not include verification that the equipment was lost, stolen, or irreparably damaged in a specific incident. Refer to the Medicare Claims Processing Manual 100-04, Chapter 20, Section 50 and Standard Documentation Requirements A55426.	30.81%
2.	The HCPCS procedure code on the claim is not correct for the item(s) billed.	18.38%
3.	The documentation does not contain a valid standard written order (SWO). Refer to Standard Documentation Requirements A55426.	15.14%
4.	The medical records do not confirm that the coverage criteria have been met for an orthotic used during ambulation.	8.11%
5.	The medical records received lack sufficient information concerning the beneficiary's condition to determine if medical necessity coverage criteria were met.	4.86%
6.	The medical record documentation is not authenticated (handwritten or electronic) by the author. Refer to the Medicare Program Integrity Manual 100-08, Chapter 3, Section 3.3.2.4.	4.32%
7.	No medical record documentation was received. Refer to the Medicare Program Integrity Manual 100-08, Chapter 3, Section 3.2.3.8.	3.78%
8.	The beneficiary was in an acute care hospital or skilled nursing facility (SNF) on this date of service. Refer to the Medicare Claims Processing Manual 100-04, Chapter 20, Sections 210-212.	3.24%
9.	The medical records do not confirm that the coverage criteria have been met for an orthotic not used during ambulation.	2.16%
10.	The claim was submitted with an incorrect modifier. Refer to the Claims Processing Manual 100-04, Chapter 20 & LCDs.	1.62%

Table 1A: Error rates for Region B

Rank	Reason	Percent
1.	The HCPCS procedure code on the claim is not correct for the item(s) billed.	28.34%
2.	The documentation does not include verification that the equipment was lost, stolen, or irreparably damaged in a specific incident. Refer to the Medicare Claims Processing Manual 100-04, Chapter 20, Section 50 and Standard Documentation Requirements A55426.	17.11%
3.	The medical records received lack sufficient information concerning the beneficiary's condition to determine if medical necessity coverage criteria were met.	13.90%
4.	The medical records do not confirm that the coverage criteria have been met for an orthotic used during ambulation.	10.16%
5.	The medical records do not confirm that the coverage criteria have been met for an orthotic not used during ambulation.	8.02%
6.	The documentation does not contain a valid standard written order (SWO). Refer to Standard Documentation Requirements A55426.	6.95%
7.	No medical record documentation was received. Refer to the Medicare Program Integrity Manual 100-08, Chapter 3, Section 3.2.3.8.	3.74%
8.	The medical record documentation is not authenticated (handwritten or electronic) by the author. Refer to the Medicare Program Integrity Manual 100-08, Chapter 3, Section 3.3.2.4.	3.21%
9.	The beneficiary was in an acute care hospital or skilled nursing facility (SNF) on this date of service. Refer to the Medicare Claims Processing Manual 100-04, Chapter 20, Sections 210-212.	2.14%
10.	The claim was submitted with an incorrect modifier. Refer to Claims Processing Manual 100-04, Chapter 20 and local coverage determinations (LCDs).	1.60%

Table 1B: Error rates for Region C

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the device will assist the patient's stability during ambulation is often a rationale to deny payment.

5) When an AFO is used for non-ambulatory purposes (e.g., plantar fasciitis or part of a stretching program for a contracted Achilles), the chart does not provide adequate documentation of the diagnosis and/or treatment. In the case of plantar fasciitis, again simply stating a diagnosis is insufficient. In the case of a patient with a contracted Achilles and equinus, the patient must have some ability to dorsiflex (not in a fixed equinus) and be participating in a physical rehabilitation program. Very often, devices described by L4396/7 are provided to nursing home patients with no potential for rehabilitation and/or to off-load a decubitus ulcer. Unfortunately, these are not covered services under Medicare.

6) Regarding Standard Written Orders (SWO), since the podiatrist is often both the prescriber and supplier, a SWO is not required. Many auditors continue to fail podiatrists and other medical providers for this reason. The standard documentation referred to in Tables 1 and 2 stipulates the exemption for a SWO when the prescriber is also the supplier. Documenting this exemption in the prescriber's note is an easy way to avoid failing an audit due to failure to provide a SWO.

Always respond to pre-payment review requests, no matter how bad your chart notes may be.

7) No medical documentation was received. Not responding to a request for records, even if you think your records are bad, is a guarantee for failing that specific audit. Far worse, it may also increase your chances of future pre-payment reviews and may guarantee a referral to ZPIC, RAC, OIG, and other organizations which conduct post-payment audits and criminal investigations. Bottom line: always respond to pre-payment review requests, no matter how bad your chart notes may be.

8) Your note was not signed in accordance with CMS signature requirements. Most EHR companies understand CMS signature requirements and successfully fulfill those requirements, often a ubiquitous step with finalizing a note. Therefore, be sure to complete and sign your notes as soon as possible. If you are hand-signing your notes, be sure that your printed name is legible and appears either below or above your signature.

9) Providing patents with DME in the in-patient setting should be a rare reason for podiatrists to fail a DMEPOS AFO audit. However, if within 48 hours of discharge, the patient may be dispensed the device for purposes of training on its use. Training on the use of the device should be incorporated into the patient's hospital record. The date of discharge, however, should be used as the date of service. Should the patient's date of discharge be delayed, the device will need to be "re-dispensed" again so that it falls within the 48-hour window. Be sure that the hospital record is both date-and-time-stamped to be sure that the "dispensing for training" conforms to the 48-hour window for discharge, or simply avoid this situation whenever possible and dispense the patient their DME device on their first office visit after their hospital discharge.

When the patient is in a SNF, it is imperative to speak with the billing office to determine whether the patient is in the SNF under Medicare Part A or B. If they have been recently discharged from the hospital, their SNF status is most likely Part A, and the SNF payment includes most orthotic/prosthetic devices under Consolidated Billing. Under these circumstances, Medicare expects the supplier to be paid

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Rank	Reason	Percent
1.	Medical records do not support that the surgical dressings are required for either the treatment of a wound caused by, or treated by, a surgical procedure; or when required after debridement of a wound.	21.61%
2.	The size of the wound in the medical records does not support the HCPCS code being billed.	9.75%
3.	Frequency of use or frequency of change is not supported by the medical records.	9.32%
4.	The monthly evaluation of the wound by the healthcare professional did not include the type of each wound, its location, its size and depth, the amount of drainage, and any other relevant information.	9.32%
5.	The medical records received lack sufficient information concerning the beneficiary's condition to determine if medical necessity coverage criteria were met.	8.47%
6.	The medical records do not show that the Alginate or other fiber gelling dressing or filler is being used to cover or fill a moderately to highly exudative full thickness wound (stage III or stage IV ulcer).	7.20%
7.	The medical records do not establish that the dressing is being used as a primary or secondary dressing or for some non-covered use (such as wound cleansing).	5.51%
8.	The medical records do not show that the Foam dressing is being used on a full thickness wound with moderate to heavy exudate (stage III or stage IV ulcer).	4.66%
9.	More than a 1-month supply of dressings were provided at one time and there was not documentation to support the necessity of greater quantities in the home setting in an individual case.	3.81%
10.	The documentation does not contain a valid standard written order (SWO). Refer to Standard Documentation Requirements A55426.	2.54%

Table 2A: Surgical Dressings Failure Rate Region B

Rank	Reason	Percent
1.	Medical records do not support that the surgical dressings are required for either the treatment of a wound caused by, or treated by, a surgical procedure; or when required after debridement of a wound.	26.46%
2.	The monthly evaluation of the wound by the healthcare professional did not include the type of each wound, its location, its size and depth, the amount of drainage, and any other relevant information.	8.31%
3.	The medical records do not establish that the dressing is being used as a primary or secondary dressing or for some non-covered use (such as wound cleansing).	7.38%
4.	The size of the wound in the medical records does not support the HCPCS code being billed.	7.38%
5.	The medical records do not show that the Alginate or other fiber gelling dressing or filler is being used to cover or fill a moderately to highly exudative full thickness wound (stage III or stage IV ulcer).	6.15%
6.	Frequency of use or frequency of change is not supported by the medical records.	5.54%
7.	The medical records do not show that the Foam dressing is being used on a full thickness wound with moderate to heavy exudate (stage III or stage IV ulcer).	5.23%
8.	The medical record documentation is not authenticated (handwritten or electronic) by the author. Refer to the Medicare Program Integrity Manual 100-08, Chapter 3, Section 3.3.2.4.	4.00%
9.	The medical records do not include an evaluation of the wounds performed on a monthly basis or justification for why they could not be evaluated monthly and what other methods were used to evaluate the need for the dressings.	4.00%
10.	The medical records do not show that the Collagen dressing is being used on full thickness wound, a wound with light to moderate exudate, or on a wound that has stalled or has not progressed towards a healing goal.	4.00%

Table 2B: Surgical Dressings Failure Rate Region C

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directly from the SNF and will reject your claim if noted upon review that it has already not been rejected on the front end during initial processing.

10) Submitting claims with the wrong modifier or without a proper modifier is a sure-fire way of having your claim rejected. For orthotic claims for the above noted HCPCS codes, both the KX (medical necessity payment) modifier is required along with a site modifier (LT/RT or both, and if both, the RT/LT must be on separate lines). This is true for both the parent code(s) and any additional HCPCS codes.

the audit in Region B and almost 36% failed in Region C (Tables 2A and 2B).

The DME MAC provided the rationale for claims denials in Tables 2A and 2B, all of which are critical elements of the surgical dressings

More than 45% of the claims undergoing pre-payment review were rejected in DME MAC B/C.

LCD and attached policy article. Similar to the analysis of AFO claims denials noted earlier in this article, one should do the same with those found in Tables 2A and 2B for surgical dressings. By conducting a similar analysis, one may find and improve any weaknesses in documentation and improve the chance of passing an audit.

ter and year after year. The advice continues to be:

1) Obtain a certification statement from the same MD/DO who is treating the DM and provides the medical examination of the patient for DM. Be sure those documents are date-sensitive to the date of shoe/insert dispensing (no more than 90 days for the certification statement and six months for the medical examination). Be sure the certification statement is dated either on the same or a future date from the examination date by the MD/DO. Be sure the MD/DO providing that documentation is actually treating the DM (if the patient is seeing both an endocrinologist and PCP, do not obtain the documentation from the PCP). The DPM documentation of foot pathology should actually be attested to and signed by the same MD/DO who is providing the previous documents and that attestation should be on the actual note the DPM wrote, not written on a separate form.

2) Be sure your notes (as the prescriber) are clear with respect to describing the patient's qualifying

Rank	Reason	Percent
1.	Medical record documentation does not include a clinical foot evaluation either conducted by the certifying physician or approved, initialed, and dated by the certifying physician. Therefore, there is no verification that the beneficiary had 1 of the 6 conditions the local coverage determination (LCD) specifies must be present for coverage.	16.50%
2.	Medical records do not include a certifying physician clinical evaluation which discusses the management of the beneficiary's systemic diabetes condition within 6 months prior to shoe delivery.	7.80%
3.	The medical record documentation is not authenticated (handwritten or electronic) by the author. Refer to the Medicare Program Integrity Manual 100-08, Chapter 3, Section 3.3.2.4.	6.80%
4.	The file does not include medical records from the certifying physician.	6.40%
5.	The medical records do not include a foot examination.	5.50%
6.	The medical records do not verify that the certifying physician is managing the patient's diabetes.	5.10%
7.	The in-person evaluation of the patient's feet is missing a description of the abnormalities the shoes/inserts/modifications will need to accommodate.	4.90%
8.	The examination documenting the medical management of the patient's diabetes may only be performed by a doctor of osteopathy (D.O.), medical doctor (M.D.), or nurse practitioner (NP) or physician assistant (PA) practicing "incident to" the supervising physician's authority. NP or PA notes pertaining to the provision of the therapeutic shoes and inserts must be reviewed and verified by the supervising physician.	4.90%
9.	Documentation did not include an in-person evaluation of the patient's feet conducted by the supplier prior to selection of the specific items.	4.60%
10.	The patient's medical records do not indicate the presence of one or more of the 6 conditions the LCD specifies must be present in order for the patient to meet coverage criteria for therapeutic shoes.	3.70%

Table 3A: DME Shoe Failure Rate Region B

Rank	Reason	Percent
1.	Medical record documentation does not include a clinical foot evaluation either conducted by the certifying physician or approved, initialed, and dated by the certifying physician. Therefore, there is no verification that the beneficiary had 1 of the 6 conditions the local coverage determination (LCD) specifies must be present for coverage.	17.33%
2.	Documentation did not include an in-person evaluation of the patient's feet conducted by the supplier prior to selection of the specific items.	6.55%
3.	The file does not include medical records from the certifying physician.	6.39%
4.	The medical records do not verify that the certifying physician is managing the patient's diabetes.	6.16%
5.	Documentation did not include a Statement of Certifying Physician.	5.01%
6.	Documentation did not include an in-person supplier visit at the time of delivery that assessed the fit of the shoes and inserts with the patient wearing them.	4.70%
7.	The medical record documentation is not authenticated (handwritten or electronic) by the author. Refer to the Medicare Program Integrity Manual 100-08, Chapter 3, Section 3.3.2.4.	4.01%
8.	Medical records do not include a certifying physician clinical evaluation which discusses the management of the beneficiary's systemic diabetes condition within 6 months prior to shoe delivery.	3.93%
9.	The in-person evaluation of the patient's feet is missing a description of the abnormalities the shoes/inserts/modifications will need to accommodate.	3.85%
10.	The examination documenting the medical management of the patient's diabetes may only be performed by a doctor of osteopathy (D.O.), medical doctor (M.D.), or nurse practitioner (NP) or physician assistant (PA) practicing "incident to" the supervising physician's authority. NP or PA notes pertaining to the provision of the therapeutic shoes and inserts must be reviewed and verified by the supervising physician.	3.54%

Table 3B: DME Shoe Failure Rate Region C

For the above stated reasons, more than 45% of the claims undergoing pre-payment review were rejected in DME MAC B/C. These ten reasons can be boiled down into one essential issue: the provider did not document the medical necessity for the device as noted in the AFO LCD or Supplementary Policy Article.

Surgical Dressings

The 2022 second quarter pre-payment review on surgical dressings was equally bad where 40% of the claims reviewed for A6010, A6021, A6196-A6199, A6209-A6212, A6203, A6231-A6233, A6234-A6241, A6242-A6248, and A6251-A6256 failed

Therapeutic Shoes

It is no surprise that topping off the failures for the second quarter of 2022 for HCPCS most often provided by podiatrists were claims for therapeutic shoes at more than 62% in DME MAC B and almost 54% in DME MAC C.

The statistical analysis of those claims failure rates may be found in Table 3A and Table 3B. In reviewing the statistics, there appear to be no surprises, and these statistics continue to be the same quarter after quar-

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findings and how the shoes/inserts will benefit the patient. If a PA/NP conducted the systemic examination to support DM management and signed the certification statement and your notes, all of those must also be countersigned/attested to by the Certifying MD/DO (unless the NP is practicing independently and is participating in a primary care first initiative program). A failure to provide an in-depth dispensing note, which accurately describes the patient wearing the shoes/inserts, continues to be problematic and can easily be rectified.

3) Lastly as with an AFO, the signature of all parties must conform with CMS signature requirements. Since most physicians' handwriting is illegible, it is best to always have the signature's name printed either below or above their actual signature (handwritten or electronic). Beware, that while electronic signatures are allowed, stamped signatures continue to be prohibited.

Summary

The DME MAC has provided this statistical analysis almost every quarter for the last several years. The reasons for audit failure can serve as a tutorial for improving your documentation. Unfortunately, the analysis provided is a snapshot of all DMEPOS suppliers and is not specific to those error rates from podiatrists.

Several attempts by representatives of numerous medical associations have attempted to secure specific data by provider type from the DME MAC and this will continue. However, past CERT data specific to podiatrists has not been much different than either the overall CERT or pre-payment review.

Efforts to continue to educate on proper DMEPOS documentation continue in many venues as does reducing the burdensome documentation required by all third-party payers.

Lastly, providers should work with their EHR partners who often have implemented tools to avoid claim submission until certain paperwork requirements are met. These essential measures can reduce needless errors and pre-payment review failures, but only if providers do not take shortcuts to sabotage those systems. **PM**

Dr. Kesselman is board certified by ABFAS and ABMSP. He is a member of the Medicare Jurisdictional Council for the DME MACs' NSC and provider portal subcommittees. He is a noted expert on durable medical equipment (DME) and an expert for Codingline.com and many third-party payers. Dr. Kesselman is also a medical advisor and consultant to many medical manufacturers and compliance organizations.