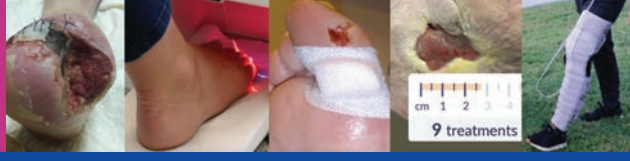

Wound Care and DME

Proper documentation reduces your error rate.

BY PAUL KESSELMAN, DPM

At the beginning of June 2023, the Comprehensive Error Rate Testing (CERT) contractor, which audits all Medicare contractor payments, held a webinar to review their 2022 data report (released December 2022). This report includes payment for all Medicare covered services paid from July 1, 2020 through June 30, 2021. Of interest to podiatrists and wound care providers was information related to Part B (medical/surgical) and DME claims. This article will concentrate on certain aspects of wound care (or its prevention) and DME, and how the CERT findings may impact your future documentation. Whenever possible, podiatry-centric documentation will be specifically pointed out.

Overall, the CERT error rate for DMEPOS was approximately 25%, which translates to an extrapolated overpayment of $2.2B. This error rate has continued to decrease over the past decade (58% in 2013), as DME providers have better educated themselves on proper documentation for DMEPOS claims. However, among the DMEPOS claims cited for very high error rates were claims related to surgical dressings, which was reported at 42% with an improper payment amount of almost $116M and "diabetic shoes" which had a 51% error rate and an improper payment amount of almost $47M. Also noted were claims where podiatrists are the referring (ordering) provider for Lower Limb Orthoses (e.g., CAM walkers, custom AFOs, night braces), amounting to an estimated 31% error rate and an improper payment rate of almost $12M.

Most of the above statistics for AFOs do not point specifically to podiatrists as the suppliers, but only as the prescribers. However, what is most troublesome is that when podiatrists are the suppliers of DMEPOS, the overall error rate for those claims is just over 55% as compared to only 15% on podiatry-related medical/surgical (Part B) claims. In comparison to other professions, podiatry-submitted DME claims contain the highest percentage of errors of any regularly submitting supplier type, even higher than for those provider types submitting fewer than 30 claims annually. In contrast, according to the CERT report, podiatry-related medical/surgical error rates are lower than those of internal medicine, cardiology, emergency medicine, and many other medical/surgical specialties.

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Why the Disparity?

The question that podiatry must confront is: why is there this disparity? In reviewing claims from colleagues with audit issues, it is apparent that podiatrists are almost always providing the services they are billing for; that is, these claims are not being submitted based on outright fraudulent or even abusive billing practices. Rather, podiatrists do an excellent job (compared to others) in their overall documentation (with certain CPT exceptions, such as for routine foot care) of the medical/surgical services they provide, but do a rather poor job of documenting the actual DMEPOS services.

Let's look at the diabetic shoe issue as one example. The policy is no doubt convoluted to the point that even the experts and auditors at the DME MAC often disagree about certain nuances in the policy. The issues of co-signature and attestation, dating, which type of provider, which provider in the group can sign, etc. are all resulting in audit failures. Podiatry also relies on another group of practitioners (MD/DO/NP/PA) for certain aspects of compliance. On the other hand, the routine foot care LCD is similarly convoluted and, in fact, the CPT codes within that policy are the number one target of auditors reviewing podiatry claims. Yet podiatry is widely successful overall with medical/surgical claims (again with exceptions for certain CPT codes such as routine foot care).

As noted previously, almost 1/3 of the claims for lower limb orthoses, where the podiatrist was the referring provider, were deemed problematic and lower limb orthoses (AFO being one category) had an almost 58% error rate with projected improper payments of approxi-

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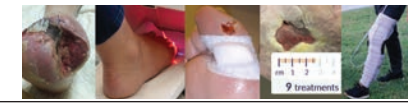

Wound Care *(from page 111)*

mately $188M. The projected error rate for lower limb orthoses and diabetic shoe claims are unacceptable; whereas for diabetic shoes, podiatrists are reliant on documentation from others. For AFOs, podiatrists are wholly responsible for the chart documentation. Yet, as noted previously, podiatry-related supplier claims have error rates which are totally unacceptable (55%). There is no specific data on podiatric supplier claims for AFOs. One can extrapolate what podiatric referral-based claims for AFOs may be. A range of 35% to 55% is unacceptable.

For surgical dressings, the CERT does not report error rates for specific referring or submitting provider type. However, it does provide some insights as to the rationale for claim deficiencies. One major issue is that of up-coding errors amounting to over $4M. One example of up-coding may be for billing for more frequent dressings than required by the patient. While the LCD on surgical dressings is quite complicated, it provides general coverage allowances and dressing change frequency for given surgical dressing classifications. The medical necessity for the quantities and frequency of dressing change, however, must still be medically necessary and appropriately supported by the chart.

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It is interesting that the CERT noted a projected underpayment rate of alginate dressings (< 16 sq. cm. A6196) of over $1.3M and $2.1M for those alginate dressings > 16 < 48 sq. cm. (A6197). That is, providers had the chart documentation to support payment for A6196/A6197 in higher amounts than submitted.

Based on similar RAC audit failures of podiatrists, despite having complete control of the documentation chain, podiatrists have done a poor job of documenting the medical necessity for surgical dressings. This is despite the fact that overall audits on surgical debridement provide excellent audit success. This disparity is unacceptable given the significant overlapping requirements of both the surgical debridement of wounds and surgical dressing LCDs.

Wound care providers such as podiatrists also billed for 99213 and 99212. The CERT reported projected underpayment amounts of $27M and $18M. While these do not reflect the performance of an evaluation and management visit on the same date of service as a "minor" surgical procedure, they nevertheless point out that many providers under-bill office visit 99212/99213, when the chart documentation may actually support it when performed as the only billable service.

On the contrary, the CERT reported an up-coding of office Evaluation and Management coding in the amount of $397M. There was a projected overpayment rate exceeding $410M for 99214 and $321M for 99233 (subsequent hospital visit). Again, as with 99213, there was nothing in the report to suggest that this overpayment was linked to the performance of another surgical procedure either on the same date (modifier -25) of service, or within the global period of a previously performed surgical procedure (modifier -24), or performed as a basis for deciding to proceed with a major surgery on the same date.

What was interesting (and good) is that podiatrists were not listed among the top 10 billers of evaluation and management codes, nor were statistics for podiatry evaluation and management codes provided in the report.

Having reviewed the CERT report in full and with the experience of reviewing many DME claims, it is apparent that podiatrists (among many other suppliers) fail to adhere to the LCD, Policy Articles, and Supplementary Instruction Articles attached to the LCD of the lower limb orthoses, diabetic shoes, and surgical dressings policies.

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It would be nearly impossible to review each requirement in this short article, but here are a few highlights and takeaway points:

AFO Claims: Provide subjective and objective findings as well as diagnosis requiring a specific AFO. Providing a history alone is unacceptable to conclude the need for an AFO. A full lower extremity examination concluding with the medical necessity rationale for the AFO (neurological and/or musculoskeletal) and specifically how the AFO will improve the patient's functional capabilities must be documented. Document any change in diagnosis or condition warranting a new or replacement device. How the new/replacement device is different than the previous device must be documented in order to successfully appeal a "Same or Similar" denial.

Consider taking photographs of the patient's foot to bolster the case of replacing a device which no longer fits. Any HCPCS code including the verbiage "includes fitting and adjustment" or "custom fit to

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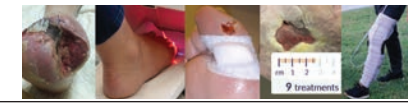

Wound Care *(from page 112)*

patient" requires special documentation. This includes providing the medical necessity for customization vs. an off-the-shelf device; that is, what was done to custom fit the device (heating, bending, molding, etc.) and that you as a podiatrist have the special training to provide such modification.

For custom fabricated devices, aside from documenting the one of multiple reasons for a custom fabricated device noted in the LCD, do not forget to document the medical necessity for every add-on code. One good example of a frequently used add-on code is L2820 (soft tissue interface) often needed to protect atrophic fragile skin. The date the patient was scanned and/or casted and the order form should be completed with all required information.

Therapeutic Shoes for Patients with Diabetes: Strictly adhere to the LCD and PA requirement of dates, and who can serve in the various roles of certifying and/or prescribing or supplier entity. If the certifying entity (MD/DO) is different than the certifying entity who signed the certification statement, it is important for the supplier to have documentation to support why there may be numerous certifying entities (group practice, where one provider is covering for another, etc.). PA signatures must be co-signed, dated, and agreed to. NPs working for an MD/DO have the same signature date requirements as PAs. Only an NP working independently and in a Primary Care First Initiative Program can act independently as the Certifying Entity.

For both AFO and Therapeutic Shoes for Patients with Diabetes: The supplier must document that the patient was examined while wearing the device (shoes/inserts/AFO) and that the fit in the length, width, etc. was good. Again, taking photographs of the patient wearing the device is further evidence to support your fitting examination. A subjective statement from the patient on the written proof of delivery stating appropriate fit is insufficient to support that a supplier fitting examination took place.

Surgical Dressings: The LCD and Policy articles are very clear with respect to the types of dressings which are reimbursed based on the type of drainage (minimal, moderate, high). The policy article also stipulates how often the dressings can be changed. Taking measurements in all three planes (length x width x depth) along with documenting the characteristics of the drainage cannot be overstated. Using a dressing on the wrong type of exudating wound type or providing an excessive amount of a specific dressing unless supported by additional documentation will certainly be met with failure upon review. The size of the surgical dressing must also be compatible with the size of the wound in order to minimize wastage.

A word on *Written Proof of Delivery (WPOD):* The CERT and other reviewers cited a lack of written proof of delivery as a fundamental basic need to pass an audit. WPOD may be completed by staff or the provider prior to dispensing, and signed and dated prior to the patient leaving the office. Medicare considers a claim to be unsupported without a WPOD. The WPOD does not have to be complicated but does need to have some basic practice and patient information, a lay description of what was dispensed (and the amount if applicable), the address of where the delivery actually took place, the patient's signature, and the date.

Illegible signatures on any forms should be supported by a printed name (no name stamps); that is, a group practice should have every MD/DO listed on their letterhead. The doctor who signed a specific form can simply circle his/her name at the top, and an illegible signature at the bottom still would comply with CMS signature requirements.

To summarize, the CERT auditor provides an annual report of claims paid by various Medicare contractors such as the local MAC (Part B Medical/Surgical), DME contractors, and others including home health, inpatient hospital, hospice, etc. The CERT report is very detailed. Studying the rationale for these errors and comparing those to your documentation can serve as a powerful useful tool for improving your documentation.

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Acting proactively can assist your practice in avoiding potential recoupments, whether from the CERT, RAC, or any other pre- or post-payment auditor. Of course, the LCD, policy articles, and other documentation for all the DMEPOS and many local MAC services you provide is as close as their website. Sign up for their E-List servers. It's free and you will be able to download policies and be provided with free updates!

Previous and current CERT reports may be found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Improper-Payment-Measurement-Programs/CERT **PM**

Dr. Kesselman is a retired board-certified podiatrist with extensive clinical and consulting experience in wound care and DME. He is a member of the Medicare Jurisdictional Councils and was an integral member of the committees involved with the initial development of LCD for Cellular Tissue Products. Dr. Kesselman is a medical advisor and consultant to many medical manufacturers, including Vaporox and is CEO of Park DPM and a partner in PARE Coding and Compliance and expert panelist for Codlingline.com. Dr. Kesselman also performs peer review for many major insurance companies.