DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®

Official CMS Information for
Medicare Fee-For-Service Providers

Medicare Quarterly Provider Compliance Newsletter

Guidance to Address Billing Errors



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Introduction

The Medicare Fee-For-Service (FFS) program consists of a number of payment systems, with a network of contractors that process more than 1 billion claims each year, submitted by more than 1 million providers, such as hospitals, physicians, skilled nursing facilities, clinical laboratories, ambulance companies, and suppliers of durable medical equipment, prosthetics, orthotics, and supplies. These contractors, called "Medicare claims processing contractors," process claims, make payments to health care providers in accordance with Medicare regulations, and educate providers regarding how to submit accurately coded claims that meet Medicare guidelines. Despite actions to prevent improper payments, such as prepayment system edits and limited medical record reviews by the claims processing contractors, it is impossible to prevent all improper payments due to the large volume of claims. In the Tax Relief and Health Care Act of 2006, the U.S. Congress authorized the expansion of the Recovery Audit Program nationwide by January 2010 to further assist the Centers for Medicare & Medicaid Services (CMS) in identifying improper payments. Medicare FFS Recovery Auditors are contractors that assist CMS by performing claim audits on a postpayment basis.

CMS issues the Medicare Quarterly Provider Compliance Newsletter, a Medicare Learning Network® (MLN) educational product, to help providers understand the major findings identified by Medicare claims processing contractors, Recovery Auditors, Program Safeguard Contractors, Zone Program Integrity Contractors, and other governmental organizations, such as the Office of Inspector General. This is the third issue of the newsletter and is designed to help FFS providers, suppliers, and their billing staffs understand their claims submission problems and how to avoid certain billing errors and other improper activities, such as failure to submit timely medical record documentation, when dealing with the Medicare FFS program.

The newsletter describes the problem, the issues that may occur as a result, the steps CMS has taken to make providers aware of the problem, and guidance on what providers need to do to avoid the problem. In addition, the newsletter refers providers to other documents for more detailed information wherever they may exist.

The findings addressed in this newsletter are listed in the Table of Contents and can be navigated to directly by "left-clicking" on the particular issue in the Table of Contents. An archive of previously-issued newsletters is also available to providers in case they missed one. This archive can be found at **http://www.cms.gov/MLNProducts/_downloads/MedQtrlyCompNL_Archive.pdf** on the CMS website. A searchable index of keywords and phrases contained in both current and previous newsletters can be found at **http://www.cms.gov/MLNProducts/downloads/MedQtrlyCompNL_Index.pdf** on the CMS website.

Recovery Audit Finding: Incorrect Discharge Status Code Inpatient Rehabilitation Facility (IRF)-Overpayment

Provider Types Affected: Inpatient Rehabilitation Facility (IRF)

Problem Description: Recovery Auditors have found that improper payments were made for Medicare beneficiaries who transferred from an inpatient rehabilitation facility (IRF) to one of the following facilities:

- Another rehabilitation facility;
- A long term care hospital;
- An inpatient hospital; or
- A nursing home.

When the preceding IRF length of stay is less than the average length of stay for the case mix group, that IRF claim should be paid a per diem amount plus an additional half day for the first day instead of the full Prospective Payment System (PPS) rate. The full PPS payment represents an improper overpayment. Please refer to the "Medicare Claims Processing Manual," Chapter 3, Section 140.2.3, at http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf on the CMS website.

Recovery Auditors have determined the Patient Status Codes shown in Table 1 on next page apply to this issue.

Guidance on How Providers Can Avoid These Problems:

✓ A patient discharge status code is a two-digit code that identifies where the patient is transferred/discharged to at the conclusion of a health care facility encounter or at the end time of a billing cycle. It should be included in Form Locator 17 on a UB-04 claim form or its electronic equivalent in the HIPAA compliant 837 format.

✓ For the IRF PPS, transfer cases are defined as those in which a Medicare beneficiary is transferred to either another rehabilitation facility, a long term care hospital, an inpatient hospital, or a nursing home that accepts payment under either the Medicare program and/or the Medicaid program AND the stay of the case is less than the average length of stay for a given Case Mix Group (CMG). The transfer policy consists of a per diem payment amount calculated by the per discharge CMG payment rate by the average length of stay for the CMG. Medicare pays transfer cases a per diem amount and include additional half day payment for the first day. Transfer payments are calculated by first adding the length of stay of the case to 0.5 (to account for the addition of the half day payment for the first day) and then multiplying the result by the CMG per diem amount.

✓ Monitor Recovery Auditor web portals to track the status of claims under Recovery Audit review for your facility. CMS has published MLN Matters® articles with specific recommendations for providers about the Recovery Auditor websites.

✓ Review these helpful Reference(s):

- The "Medicare Claims Processing Manual," Chapter 3, Section 140.2.3, can be found at http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf on the CMS website.
- MLN Matters® Article #SE0801, "Clarification of Patient Discharge Status Codes and Hospital Transfer Policies," can be found at http://www.cms.gov/MLNMattersArticles/downloads/SE0801.pdf on the CMS website)
- MLN Matters® Article #SE0459, "Clarification of Medicare's Transfer Policy Under the Inpatient Prospective Payment System (IPPS)," can be found at http://www.cms.gov/MLNMattersArticles/downloads/SE0459.pdf on the CMS website)
- MLN Matters® Article #MM5354, "New Edits Established to Enforce Proper Transfer Coding and Payment in Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) Claims, can be found at http://www.cms.gov/MLNMattersArticles/downloads/MM5354.pdf on the CMS website.
- The US Department of Health and Human Services Office of the Inspector General (OIG)

Report, A-04-04-00008, dated 2006, "Nationwide Review of Inpatient Rehabilitation Facilities' Compliance with Medicare's Transfer Regulation," can be found at http://oig.hhs.gov/oas/reports/region4/40400008.pdf on the OIG website.

- MLN Matters® Article #SE1024 contains a list of the Recovery Audit Program contractors and their websites. The article can be found at http://www.cms.gov/MLNMattersArticles/downloads/SE1024.pdf on the CMS website.

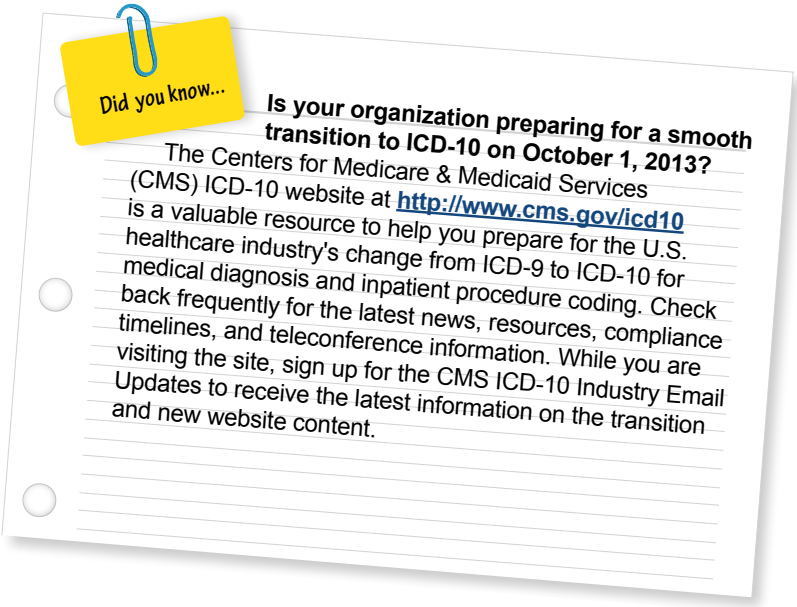


Table 1: Applicable Patient Status Codes

Patient Status Code	Code Descriptor
01	Discharge to Home or Self Care (Routine Discharge)
02	Discharged/Transferred to a Short-term General Hospital for Inpatient Care
03	Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care.
04	Discharged/Transferred to an Intermediate Care Facility (ICF)05 - Discharged/Transferred to a Designated Cancer Center or Children's Hospital
05	Discharged/Transferred to Another Type of Health Care Institution Not Defined Elsewhere in This Code List
06	Discharged/Transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care
07	Left Against Medical Advice or Discontinued Care
43	Discharged/Transferred to a Federal Hospital
50	Discharged/Transferred to a Hospice-Home
51	Discharged/Transferred to a Hospice medical facility
61	Discharged/Transferred to a Hospital-based Medicare Approved Swing Bed
62	Discharged/Transferred to an Inpatient Rehabilitation Facility Including Distinct Part Units of a Hospital
63	Discharged/Transferred to Long Term Care Hospitals
64	Discharged/Transferred to a Nursing Facility Certified Under Medicaid but not Certified Under Medicare
65	Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital
66	Discharged/Transferred to a Critical Access Hospital (CAH)
70	Discharged/Transferred to another type of health care institution not defined elsewhere in this code list

Recovery Audit Finding: Incorrect Patient Status Code Inpatient Rehabilitation Facility (IRF)– Underpayment

Provider Types Affected: Inpatient Rehabilitation Facility (IRF)

Problem Description: Recovery Auditors determined that Inpatient Rehabilitation Facilities (IRF) stays were billed with incorrect patient (discharge) status codes after transferring a patient to another facility. The reimbursement for the IRF was underpaid based on the type of facility the patient was subsequently transferred to or the absence of any subsequent facility claim.

Recovery Auditors have determined the Patient Status Codes shown in Table 2 on next page apply to this issue.

Guidance on How Providers Can Avoid These Problems:

✓ For the Inpatient Rehabilitation Facility-Prospective Payment System (IRF-PPS), transfer cases are defined as those in which:

- A Medicare beneficiary is transferred to another facility including:
  - Another rehabilitation facility (patient status code 62),
  - A long term care hospital (patient status code 63),
  - An inpatient hospital (patient status code 02), **or**
  - A nursing home that accepts payment under either the Medicare program and/ or the Medicaid program (patient status codes 03, 61, or 64); **AND**
- The length of stay (LOS) of the case is less than the average length of stay (ALS) for a given Case-Mix Group (CMG).

✓ The transfer policy consists of a per diem payment amount, which is calculated **by dividing 1**) the per discharge CMG payment rate **by 2**) the average LOS for the CMG. Medicare pays transfer cases a per diem amount, and an additional half day payment for the first day. Transfer payments are calculated by:

- First adding the LOS of the case to 0.5 (to account for the addition of the half day payment for the first day), and
- Then multiplying the result by the CMG per diem amount.

✓ A transfer is determined if the patient is discharged from one facility and admitted to another facility on the day of discharge. If a patient is discharged and admitted to another facility other than the day of discharge from the first facility, this does not fall within the CMS transfer policy.

For Example:

- If a patient is discharged and admitted to a second facility the second day after discharge, this is not treated as a transfer within CMS guidelines or Medicare System edits.
- If a patient is discharged on April 3rd from a facility and the claim is billed with an '02' patient status code indicating the patient was transferred to an acute (short-term) hospital, but Medicare Systems do not reflect another hospital claim with the admit date equal to the discharge date, the first claim was billed incorrectly as well as reimbursed incorrectly. This reflects an underpayment as the first facility claim (billed with a Patient Status Code 02) was paid a per diem amount when they should have received the full DRG amount.

✓ It is important to select the correct patient discharge status code, and in cases in which two or more patient discharge status codes apply, you should code the highest level of care known. Omitting a code or submitting a claim with an incorrect code is a claim billing error and could result in your claim being rejected or your claim being cancelled and payment being taken back. Applying the correct code will help assure that you receive prompt and correct payment.

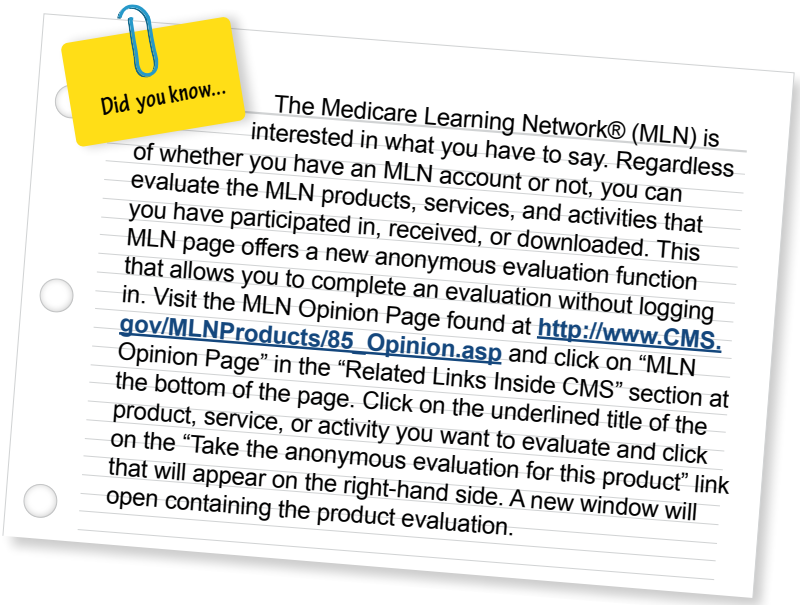
✓ Monitor Recovery Auditor web portals to track the status of claims under Recovery Audit review for your facility. CMS has published MLN Matters® articles with specific recommendations for providers about Recovery Auditor websites.

✓ Review these helpful Reference(s):

- The "Medicare Claims Processing Manual," Chapter 3, Section 140.2.3, can be found at http://www.cms.gov/manuals/downloads/clm104c03.pdf on the CMS website.
- MLN Matters® Article #SE0801, "Clarification of Patient Discharge Status Codes and Hospital Transfer Policies," can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0801.pdf on the CMS website.
- MLN Matters® Article #SE0459, "Clarification of Medicare's Transfer Policy Under the Inpatient Prospective Payment System (IPPS)," can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0459.pdf on the CMS website.
- MLN Matters® Article #MM5354, "New Edits Established to Enforce Proper Transfer Coding and Payment in Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) Claims," can be found at http://www.cms.gov/MLNMattersArticles/downloads/MM5354.pdf on the CMS website.
- OIG Report, A-04-04-00008, dated September 2006, "Nationwide Review of Inpatient Rehabilitation Facilities' Compliance with Medicare's Transfer Regulation," can be found at http://oig.hhs.gov/oas/reports/region4/40400008.pdf on the OIG website.

Table 2: Applicable Patient Status Codes

Patient Status Code	Code Descriptor
02	Discharged/Transferred to a Short-term General Hospital for Inpatient Care
03	Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care.
61	Discharges/Transferred to a Hospital-based Swing Bed facility
62	Discharged/Transferred to an Inpatient Rehabilitation Facility Including Distinct Part Units of a Hospital
63	Discharged/Transferred to Long Term Care Hospitals



Recovery Audit Finding: Coagulation Disorders–Improper Coding of MS-DRG 813 Coagulation Disorders

Provider Types Affected: Inpatient Hospital

Problem Description:

The Recovery Auditors found an overwhelming majority of errors in assignment for MS-DRG 813 Coagulation Disorders, resulting in overpayments to hospitals.

The auditors identified errors in the data that could be traced to the hospitals' medical record practice. An analysis of the billing data indicates that a potential aberrant billing practice may exist for MS-DRG 813 Coagulation Disorders.

The following example presents the problem:

- The patient was transfused and Coumadin was held until the International Normalized Ratio (INR) normalized. This billing was erroneously coded as principal diagnosis 286.9 - Other and Unspecified Coagulation Defect and DRG 813 Coagulation Disorders. It should have been coded as 790.92- Abnormal Coagulation Profile and E934.2 - Adverse Effects of Anticoagulants in Therapeutic Use. The DRG 813 should have been DRG 948. Source: The American Hospital Association (AHA) "Coding Clinic Fourth Quarter 1993," page 29.

Guidance on How Providers Can Avoid These Problems:

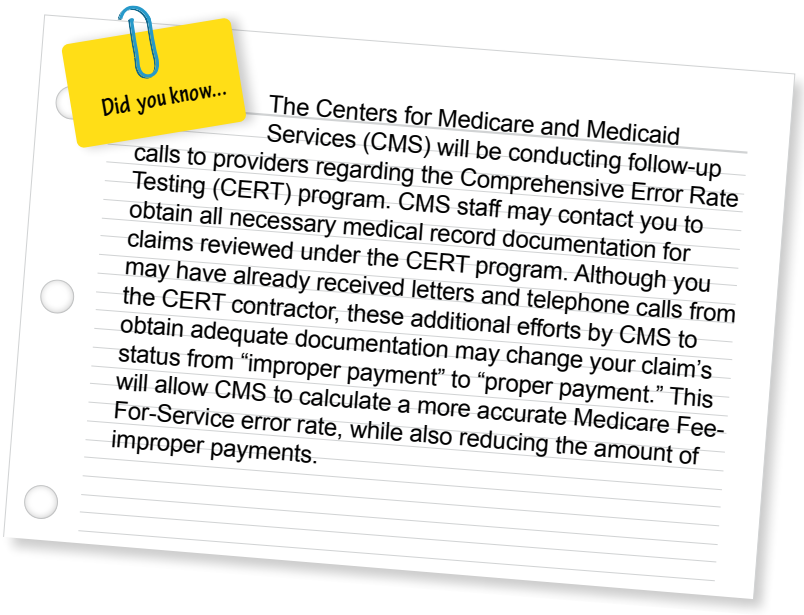
✓ Hospitals should ensure that their billing staffs are up to date on the guidelines for coding diagnoses for patients with coagulation disorders, adverse effects of anticoagulants in therapeutic use and coagulation profile.

✓ The following may help coding staff ensure complete and accurate coding:

- The "ICD-9 CM for Hospitals," Volumes 1, 2, and 3; "Guidelines for Coding and Reporting," and "ICD-9-CM Addendums and Coding Clinics" (2007-2009), can be found at http://www.cdc.gov/nchs/data/icd9/icdguide10.pdf on the Centers for Disease Control and Prevention (CDC) website, especially:

1. ICD-9-CM for Hospitals Vol. 1, 2 & 3, Coding Guidelines, Section II, A, B, C, D, E, F, G, H (2007–2009)
2. ICD-9-CM Addendums and Coding Clinics (2007–2009)

- The "Medicare Program Integrity Manual," sections 6.5.3 (DRG Validation Review) and 6.5.4 ((Review of Procedures Affecting the DRG), which contain the guidelines Medicare contractors use in conducting medical review. These sections of the manual can be found in Chapter 6 at http://www.cms.gov/manuals/downloads/pim83c06.pdf on the CMS website.



Recovery Audit Finding: Recovery Audit Finding: Human Immunodeficiency Virus (HIV) Disease – Wrong Diagnosis Code or Wrong Principal Diagnosis Code Billed

Provider Types Affected: Inpatient Hospital

Problem Description:

The Recovery Auditors reviewed claims where the diagnosis code 042 Human Immunodeficiency Virus (HIV) Disease was billed as the secondary diagnosis.

The "ICD-9 CM Official Guidelines for Coding and Reporting" states that, if a patient is admitted for an HIV- related condition, the principal diagnosis should be 042, followed by additional diagnosis codes for all reported HIV- related conditions. (Refer to "Human Immunodeficiency Virus (HIV) Infections," Section I.C.1.a.2.(a), page 13.)

In addition, the guidelines state that patients with any known prior diagnosis of an HIV- related illness should be coded 042. Once a patient has developed an HIV-related illness, the patient should always be assigned the code 042 on every subsequent admission/ encounter. However, this does not mean that 042 must be the principal diagnosis. If the condition responsible for the admission is AIDS related (on the MDC 25 list or tied to AIDS by the physician in documentation), 042 is the appropriate principal diagnosis. If the admission was prompted by an unrelated illness, the principal diagnosis is that illness, and 042 is a secondary diagnosis. (Refer to "Human Immunodeficiency Virus (HIV) Infections," Section I.C.1.a.2.(b), page 14.)

Guidance on How Providers Can Avoid These Problems:

- ✓ Hospitals should ensure that their billing staff reviews the guidelines for correctly coding and sequencing principal and secondary diagnoses for patients with HIV.
- ✓ When billing for patients admitted for an HIV- related condition, the principal diagnosis is coded as 042, followed by additional diagnosis codes for all reported HIV related conditions.
- ✓ When billing for patients with any known prior diagnosis of an HIV- related illness, the billing is coded to 042.
- ✓ Once a patient has developed an HIV related illness, the patient should always be assigned the code 042 on every subsequent admission/ encounter.
- ✓ If a patient with HIV disease is admitted for an unrelated condition, such as a traumatic injury, the code for the unrelated condition (e.g., the nature of injury code) should be the principal diagnosis. Other diagnoses would be 042 followed by additional diagnosis codes for all reported HIV-related conditions.
- ✓ Whether the patient is newly diagnosed or has had previous admissions/ encounters for HIV conditions is irrelevant to the sequencing decision.
- ✓ Understand that Medicare claims reviewers will follow the medical review procedures for DRG verification in the "Medicare Program Integrity Manual," Chapter 6, and "Quality Improvement Organization Manual," Chapter 4130. Those procedures use the official ICD-9 CM coding guidelines.
- ✓ The following may help coding staff ensure complete and accurate coding:
  - The "ICD-9 CM Official Guidelines for Coding and Reporting" can be found at **http://www.cdc.gov/nchs/data/icd9/icdguide10.pdf** on the CDC website.
  - The American Medical Association Current Procedural Terminology references.
  - The "Medicare Program Integrity Manual," sections 6.5.3 (DRG Validation Review) and 6.5.4 ((Review of Procedures Affecting the DRG) contains the guidelines Medicare contractors use in conducting medical review. These sections of the manual can be found in Chapter 6 at **http://www.cms.gov/manuals/downloads/pim83c06.pdf** on the CMS website.

Recovery Audit Finding: Oxaliplatin–Dose vs. Billed Units

Provider Types Affected: Outpatient Hospitals

Problem Description:

The purpose of the Recovery Auditors review was to determine whether the hospital Outpatient Prospective Payment System (OPPS) and Professional Providers have billed the correct number of service units for Oxaliplatin.

For outpatient services furnished before July 1, 2003, CMS instructed hospitals to bill for Oxaliplatin using HCPCS code J3490, and the service unit for that code was 0.5 milligrams.

For outpatient services furnished from July 1, 2003, to December 31, 2005, hospitals were instructed to use Healthcare Common Procedure Coding System (HCPCS) code C9205 to report the administration of Oxaliplatin. The descriptor for HCPCS code C9205 was "Injection, Oxaliplatin, per 5 mg."

For outpatient services furnished on or after January 1, 2006, hospitals were instructed to use HCPCS code J9263 to report the administration of Oxaliplatin. The descriptor for HCPCS code J9263 is "Injection Oxaliplatin 0.5 mg."

Due to the vast difference in the amounts used (5.0 mg or 0.5mg) to calculate the number of service units being billed, Recovery Auditors found that many hospitals incorrectly calculated the number of service units billed, resulting in overpayment.

Covered Indications and Documentation Requirements:

Oxaliplatin (Eloxatin™) is an anti-cancer chemotherapeutic agent approved by the Food and Drug Administration (FDA) for the treatment of colorectal cancer. Anti-cancer chemotherapeutic agents are eligible for coverage when used in accordance with FDA-approved labeling, when the off-label use is supported in one of the authoritative drug compendia listed in Section 1861(t)(2)(B)(ii)(I), or when the Medicare contractor determines an off-label use is medically accepted based on guidance provided by the Secretary (section 1861(t)(2)(B)(ii)(II)). Please refer to Section 1861(t)(2)(B) of the Social Security Act (the Act) at **http://www.ssa.gov/OP_Home/ssact/title18/1861.htm** on the Social Security Administration (SSA) website.

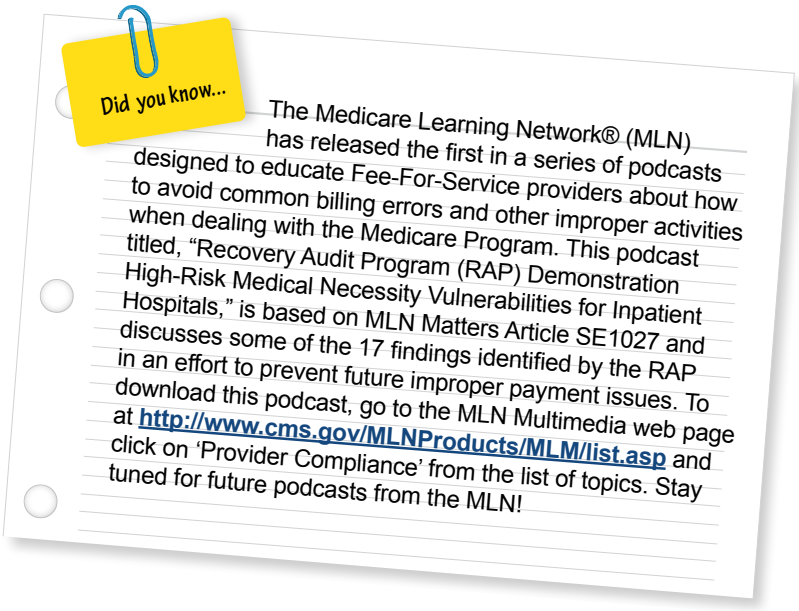
Pursuant to the national coverage determination, the off-label use of clinical items and services, including the use of the studied drugs Oxaliplatin and other selected anticancer chemotherapeutic agents, are covered in specific clinical trials identified by CMS. The clinical trials identified by CMS for coverage of clinical items and services are sponsored by the National Cancer Institute (NCI) and study the use of one or more off-label uses of these four drugs in colorectal cancer and in other cancer types.

The list of identified trials can be found at **http://www.cms.hhs.gov/coverage/download/id90b.pdf** on the CMS website.

Guidance on How Providers Can Avoid These Problems:

- ✓ It is important that billing staff use the recurring (annual and quarterly) OPPS updates because many HCPCS codes for drugs, biologicals, and radiopharmaceuticals can undergo changes in their HCPCS code descriptors that are effective each new Calendar Year (CY) or quarter. In addition, several temporary codes can be deleted and replaced with permanent HCPCS codes.
- ✓ Hospitals are strongly encouraged to report charges for all drugs, biological and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. Hospitals should bill for these products making certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug, biological or radiopharmaceutical that was actually administered to the patient and billing for units of service consistent with the dosages contained in the long descriptors of the active HCPCS codes approved for that CY.

- ✓ Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986, P.L. No. 99-509, requires hospitals to report claims for outpatient services using HCPCS codes. The "Medicare Claims Processing Manual," Chapter 4, Section 20.4, states: "The definition of service units . . . is the number of times the service or procedure being reported was performed."
- ✓ The definition of service units (FL 46 on the Form CMS-1450) where HCPCS code reporting is required is the number of times the service or procedure being reported was performed. For example: The descriptor for HCPCS code C9205 is "Injection, Oxaliplatin, per 5 mg [milligrams]."
- ✓ For outpatient services furnished on or after January 1, 2006, hospitals were instructed to use HCPCS code J9263 to report the administration of Oxaliplatin. The descriptor for HCPCS code J9263 is "Injection Oxaliplatin 0.5 mg." In this case, one service unit would be billed if 0.5 mg of Oxaliplatin had been administered to a patient. Please refer to the "Medicare Claims Processing Manual," Chapter 4, Section 20.4, which can be found at **http://www.cms.gov/manuals/downloads/clm104c04.pdf** on the CMS website.
- ✓ Review these helpful Reference(s):
  - "Federal Register," Vol.70, No.217/Thursday, November 10, 2005/Rules and Regulations Health and Human Services, can be found at **http://edocket.access.gpo.gov/2005/pdf/05-22136.pdf** on the U.S. Government Printing Office (GPO) website.
  - CMS Transmittal 786, Change Request 4250, can be found at **http://www.cms.hhs.gov/transmittals/downloads/R786CP.pdf** on the CMS website.
  - MLN Matters® Article #MM3742, "Anti-Cancer Chemotherapy for Colorectal Cancer," can be found at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3742.pdf** on the CMS website.
  - The clinical trials identified by CMS can be found at **http://www.cms.hhs.gov/coverage/download/id90b.pdf** on the CMS website.
  - CMS Transmittal 588, Change Request 3742, can be found at **http://www.cms.hhs.gov/transmittals/downloads/R588CP.pdf** on the CMS website.
  - OIG Report, A-05-09-00052, dated August 2009, "Review of Oxaliplatin Claims Processed by National Government Services for Calendar Years 2004 AND 2005," can be found at **http://oig.hhs.gov/oas/reports/region5/50900052.pdf** on the OIG website.
  - OIG Report, A-04-09-06100, dated July 2009, "Review of Medicare Outpatient Payments For Oxaliplatin in Kentucky," can be found at **http://oig.hhs.gov/oas/reports/region4/40906100.pdf** on the OIG website.



Recovery Audit Finding: Extensive OR procedure unrelated to Principal Diagnosis DRG 468 MS-DRG 981,982,983

Provider Types Affected: Inpatient Hospital

Problem Description:

The purpose of DRG validation is to ensure that a beneficiary's diagnostic and procedural information, and discharge status (as the hospital coded and reported on its claim) match both the attending physician's description and the information contained in the beneficiary's medical record; and to determine that the principal diagnosis and all secondary diagnoses identified as complications/co-morbidities (CC) and major complications/co-morbidities (MCC) are actually present, correctly sequenced, and coded.

Auditors performed DRG validation on the following MS DRGs (formerly DRG 468):

- MS-DRG 981 – Extensive operating room procedure unrelated to principal diagnosis with MCC;
- MS-DRG 982 – Extensive operating room procedure unrelated to principal diagnosis with CC; and
- MS-DRG 983 – Extensive operating room procedures unrelated to principal diagnosis without CC or MCC

During the audit, they found many errors in the assignment for MS-DRG 981, MS-DRG 982, and MS-DRG 983 that resulted in overpayments to hospitals.

Guidance on How Providers Can Avoid These Problems:

✓ When a patient is admitted to the hospital, the health condition that (after physician assessment) is determined to be chiefly responsible as the cause for the admission should be sequenced as the principal diagnosis (coded as an MS DRG). Other identified diagnoses should represent all MCCs and CCs present during the admission that impact the hospital stay. In addition, the present on admission (POA) indicator for all diagnoses reported (both principal and secondary) must be coded correctly.

✓ All medical documentation entries must be consistent with other parts of the medical record (assessments, treatment plans, physician orders, nursing notes, medication and treatment records, etc.); and with other facility documents such as admission and discharge data and pharmacy records). If an entry is made that contradicts documentation found elsewhere in the record, clarification should be obtained and documented by the attending physician.

✓ The hospital's claim must match both the attending physician's description/diagnosis and the information contained in the beneficiary's medical record.

✓ Review these helpful Reference(s):

- MLN Matters® Article #SE1024 contains a list of the Recovery Audit Program contractors and their websites. The article can be found at **http://www.cms.gov/MLNMattersArticles/downloads/SE1024.pdf** on the CMS website.
- The "Medicare Program Integrity Manual," Chapter 6 (Intermediary MR Guidelines for Specific Services), Section 6.5.3 (DRG Validation Review) discusses the DRG validation process and some coding requirements and can be found at **http://www.cms.gov/manuals/downloads/pim83c06.pdf** on the CMS website.
- MLN Matters® Article #MM5499, "Present On Admission (POA) Indicator," can be found at **http://www.cms.gov/MLNMattersArticles/downloads/MM5499.pdf** on the CMS website.
- OIG Report, OAI-12-801170, dated September 1989, "DRG 468: Unrelated Operating Room Procedures," can be found at **http://www.oig.hhs.gov/oei/reports/oai-12-88-01170.pdf** on the OIG website.

Recovery Audit Finding: Untimed Codes—Excessive Units

Provider Types Affected: Physician, Nonphysician Practitioners and Outpatient Hospital

Problem Description:

Untimed codes are used by providers to bill for services that are not defined by specific time frames. The reimbursement for untimed codes is fixed. No matter how long the evaluation or service, providers can bill only one unit of untimed codes for a patient per date of service with some exceptions.

The following two scenarios exemplify reasons for adjustments the Recovery Auditors make in order to align provider payments with Medicare guidelines for untimed codes. These codes relate to coverage of outpatient rehabilitation therapy services: physical therapy, occupational therapy, and speech-language pathology services.

1. An 84-year-old male received services for untimed therapy at an acute hospital. The date of service is August 3, 2009, through August 31, 2009. The untimed therapy CPT code of 92526 (treatment of swallowing dysfunction and/or oral functions for feeding) was billed on this claim with two services billed on separate lines with the same line date of service. The Recovery Audit adjustment was processed to recoup one service that was billed multiple times allowing only one service for the line date of service.
2. A 76-year-old male received therapy services at a Critical Access Hospital (CAH). The claim date of service is May 5, 2009, through May 28, 2009. The untimed therapy CPT of 92507 (treatment of speech, language, voice, communication and/or auditory processing disorder; individual) was billed on this claim for eight different days with four units each day. The Recovery Audit adjustment was processed to recoup three units for each of the eight days where four units were billed per line date of service allowing only one service for each line date of service.

Guidance on How Providers Can Avoid These Problems:

✓ When reporting service units for untimed codes (excluding Modifiers -KX, and -59) where the procedure is not defined by a specific timeframe, enter a 1 in the 'units bill' column per date of service.

EXAMPLE: A beneficiary received a speech-language pathology evaluation represented by HCPCS "untimed" code 92506. Regardless of the number of minutes spent providing this service only one unit of service is appropriately billed on the same day. This example can be found in the "Medicare Claims Processing Manual" Chapter 5, Section 20.2, page 24, at: http://www.cms.gov/manuals/downloads/clm104c05.pdf on the CMS website.

✓ Certain services are limited to certain numbers of units per day for physical therapy, occupational therapy and speech-language pathology, separately to control inappropriate billing. The limitations on outpatient therapy services are consistent with the provisions of the Deficit Reduction Act (DRA) of 2005.

✓ Specifically, the HCPCS codes involved are: 90901, 92506, 92507, 92508, 92526, 92597, 92605, 92606, 92609, 92610, 92611, 92612, 92614, 92616, 95833, 95834, 96110, 97001, 97002, 97003, 97004, 97010, 97022, 97026, 97597 and 97598.

✓ Review these helpful Reference(s):

- Transmittal 1019, Change Request 5253, pages 7-11, can be found at https://www.cms.gov/transmittals/downloads/R1019CP.pdf on the CMS website.
- The "Medicare Benefit Policy Manual," Chapter 15, Section 220, can be found at http://www.cms.gov/manuals/Downloads/bp102c15.pdf on the CMS website.

- The "Medicare Benefit Policy Manual," Chapter 12, Section 40.4, which describes services provided in a Comprehensive Outpatient Rehabilitation Facility (CORF), can be found at **http://www.cms.gov/manuals/Downloads/bp102c12.pdf** on the CMS website.

Did you know...

If you are a Medicare Fee-For-Service (FFS) physician, provider, or supplier submitting claims to Medicare for payment, this is very important information you need to know. Effective immediately, any Medicare Fee-For-Service claim with a date of service on or after January 1, 2010, must be received by your Medicare contractor no later than one Calendar Year (12 months) from the claim's date of service–or Medicare will deny the claim. For additional information, see Medicare Learning Network (MLN) Matters® Articles MM6960 at **http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf** and MM7080 at **http://www.cms.gov/MLNMattersArticles/downloads/MM7080.pdf** on the Centers for Medicare & Medicaid Services (CMS) website. You can also listen to a podcast on this subject by visiting **http://www.cms.gov/MLNProducts/MLM/list.asp** on the same site.tuned for future podcasts from the MLN!

Recovery Audit Finding: Technical Component of Radiology

Provider Types Affected: Radiology Suppliers, Physician, Non-Physician Practitioners

Problem Description:

The technical component (TC) of radiology services furnished to patients in a Prospective Payment System (PPS) hospital setting may not be billed separately to Part B. Under Medicare's PPS, Medicare Contractors reimburse acute care hospitals a predetermined amount for services furnished to Medicare beneficiaries based on their illness and its classification under a diagnosis-related group (DRG). The DRG payment for inpatient services covers non-physician outpatient services that Medicare beneficiaries receive during an inpatient stay. These non-physician outpatient services include radiology services, such as tomography scans, furnished to inpatients by a physician's office, another hospital, or a radiology clinic. Accordingly, radiology suppliers that render non-physician outpatient services during inpatient stays are required to bill the PPS hospitals, not the Medicare carriers, for those services. Radiology services furnished to hospital outpatients are paid under the Outpatient Prospective Payment System (OPPS) to the hospital.

The TC of radiology services for hospital inpatients, except Critical Access Hospitals (CAHs), is included in the PPS payment to hospitals. Hospital bundling rules exclude payment to suppliers of the TC of a radiology service for beneficiaries in a hospital inpatient stay. Radiology services furnished to hospital outpatients are paid under the OPPS to the hospital.

The following two scenarios exemplify reasons for adjustments the Recovery Auditors make in order to align provider payments with Medicare guidelines.

1. An 80-year-old female was admitted to an inpatient hospital stay on January 24, 2010, and was discharged on February 8, 2010. A physician billed CPT Code 71010 (Chest x-ray) for date of service January 26, 2010. CPT Code 71010 has a professional component/ technical component (PC/TC) indicator of "1", with a global allowed amount of $23.73 and a paid amount of $18.98. The date of service, January 26, 2010, was during the inpatient hospital stay and data analysis confirms the patient was not on leave-of-absence from the hospital on that date. The TC portion of this code was only payable to the facility while the patient is in an inpatient setting. CPT Code 71010 was adjusted to pay only for the PC portion, by applying "new modifier" 26 to the claim. The allowed amount for CPT Code 71010 with modifier 26 was $9.03. The new provider paid amount was $7.22. This resulted in a total recouped amount of $11.76.
2. A 60-year-old male received radiology services in an outpatient hospital setting on date of service June 5, 2008. A physician billed CPT code 77401 (Radiation treatment delivery) for date of service June 5, 2008, which was the same date as the outpatient hospital claim. CPT Code 77401 had a PC/TC indicator of "3", with an allowed amount of $27.30 and a total paid amount of $21.84. Codes with a PC/TC indicator of "3" are TC only codes. The TC of a code is payable only to the facility when a patient is in an outpatient hospital setting. CPT Code 77401 was adjusted to recoup the total paid amount of $21.84.

Guidance on How Providers Can Avoid These Problems:

- ✓ Be aware that Medicare claims processing contractors cannot pay for the TC of radiology services furnished to patients in inpatient or outpatient settings. Under the PPS for acute care hospitals, suppliers that render non-physician Part B services during inpatient stays are required to bill the hospitals, not the Medicare carriers, for those services.
- ✓ Remember that radiology services for beneficiaries in a hospital inpatient stay are part of the hospital bundled payment.

✓ Review these helpful Reference(s):

- The "Medicare Claims Processing Manual," Chapter 13 Sections 20.2.1, can be found at http://www.cms.gov/manuals/downloads/clm104c13.pdf on the CMS website. This section describes the parameters around which the TC of radiology services furnished to hospital patients is reimbursed.
- MLN Matters® Article #MM5347, "Common Working File (CWF) Duplicate Claim Edit for the Technical Component (TC) of Radiology and Pathology Laboratory Services Provided to Hospital Patients'," can be found at http://www.cms.gov/MLNMattersArticles/downloads/MM5347.pdf on the CMS website.
- OIG Report, A-01-04-00528, dated August 2006, "Medicare Part B Payments for Radiology Services Provided During Inpatient Stays: 2001 Through 2003," can be found at http://oig.hhs.gov/oas/reports/region1/10400528.pdf on the GPO website.

Did you know...

Looking for the latest Medicare Fee-For-Service (FFS) information? Then subscribe to a Medicare FFS Provider listserv that suits your needs! For information on how to register and start receiving the latest news, go to http://www.cms.gov/MLNProducts/downloads/MailingLists_FactSheet.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Special Edition (SE) Articles Regarding Findings of the Office of Inspector General

SE1102 – Inappropriate Medicare Payments for Transforaminal Epidural Injection Services

Provider Types Affected:

Physicians who bill Medicare contractors (carriers or Medicare Administrative Contractors (A/B MAC)) for providing transforaminal epidural injection services to Medicare beneficiaries are affected.

Issue:

This MLN Matters® Special Edition article is based on the August 2010 Department of Health and Human Services Office of the Inspector General (OIG) report titled "Inappropriate Medicare Payments For Transforaminal Epidural Injection Services."

It summarizes the study's objectives which were: 1) To determine the extent to which Medicare Part B physician payments for transforaminal epidural injections met Medicare requirements, and 2) To determine the safeguards that existed to ensure Medicare Part B payments for transforaminal epidural injections met Medicare requirements. The report also describes the study's identified problems with transforaminal epidural injections; and its findings and recommendations. This article is intended to remind physicians of the importance of properly documenting the services for which they bill and to assure the documentation meets Medicare's requirements. In addition, the documentation must show such services meet Medicare's medical necessity requirements. The article can be found at **http://www.cms.gov/MLNMattersArticles/downloads/SE1102.pdf** on the CMS website.

SE1103 – Capped Rental DME: Enforcement of Payment Requirements for Beneficiary-owned Capped Rental Durable Medical Equipment (DME)

Provider Types Affected:

Suppliers who submit claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries for capped rental DME equipment.

Issue:

This article is primarily informational and summarizes the findings of the OIG report of August of 2010 titled, "A Review of Claims for Capped Rental Durable Medical Equipment." The article contains references to Medicare policy documents that CMS has available to guide suppliers in proper billing of capped rental DME claims, including repairs and maintenance.

Suppliers need to be aware of the report findings and proper billing procedures to avoid impact on claims payments. The OIG report is available at **http://oig.hhs.gov/oei/reports/oei-07-08-00550.pdf** and provides details about the findings. In addition to the procedures for proper billing, suppliers should follow all proper documentation requirements to assure that the documentation adequately supports claims for payment. The MLN Matters® article related to this report can be found at **http://www.cms.gov/MLNMattersArticles/downloads/SE1103.pdf** on the CMS website.

SE1104 – The Importance of Correctly Coding the Place of Service by Physicians and Their Billing Agents

Provider Types Affected:

Physicians and their billing agents who submit claims to Medicare Carriers or Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

Issue:

Incorrectly coding the place of service code on claims could result in overpayments that will need to be recovered. The OIG conducted an audit to determine whether physicians correctly coded non-facility places of service on selected Part B claims submitted to and paid by Medicare contractors. The report, titled "Review of Place-of-Service Coding For Physician Services Processed By Medicare Part B Carriers During Calendar

Special Edition (SE) Articles Regarding Findings of the Office of Inspector General

Year 2007," can be found at http://oig.hhs.gov/oas/reports/region1/10900503.asp on the OIG website.

The OIG found that, in many instances, physicians are incorrectly coding the place-of-service code. Specifically, in a very large portion of the claims audited, physicians used non-facility place-of-service codes on their claims for services that were actually performed in hospital outpatient departments or ASCs. This led to overpayments by Medicare on these claims. Medicare does recover these overpayments so it is critical to code correctly and avoid overpayments. The MLN Matters® article related to this report can be found at http://www.cms.gov/MLNMattersArticles/downloads/SE1103.pdf on the CMS website.

Did you know...

The March 2011 version of the Medicare Learning Network® Products Catalog is now available! The MLN Products Catalog is a free interactive downloadable document that lists all MLN products by media format. To access the catalog, visit http://www.CMS.gov/MLNGenInfo and select the "MLN Products Catalog" in the "Downloads" section. Once you have opened the catalog, you may either click on the title of a product or the type of "Formats Available."

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