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

Volume 2, Issue 1 - October 2011

ICN907163 October 2011

Table of Contents

Introduction

The Medicare Fee-For-Service (FFS) program contains 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, including hospitals, physicians, Skilled Nursing Facilities, clinical laboratories, ambulance companies, and suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). 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 pre-payment 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 post-payment basis.

Recovery Auditors are required to use clinicians, such as registered nurses or therapists for coverage/medical necessity determinations, and certified coders for coding determinations. Auditors are not authorized to go outside of their scope of practice. Some reviews may require the skills of both a clinician and a coder.

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 Administrative Contractors (MACs), Recovery Auditors, Program Safeguard Contractors, Zone Program Integrity Contractors, and other governmental organizations, such as the Office of Inspector General. This is the first issue in the second year 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. 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.

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 issue. 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. 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.

Important Note:

The April 2011 Newsletter (**http://www.cms.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN903696.pdf**) was revised on October 5, 2011, to amend an entry on page 10 (Untimed Codes—Excessive Units). Specifically, the bullet point immediately after "**Guidance on How Providers Can Avoid These Problems**" in the middle column of page 10 of that issue was revised.

Recovery Audit Finding: Incorrect Facility vs. Non-Facility Reimbursement

Provider Types Affected: Physicians who bill for services provided to a Medicare beneficiary in a facility setting

Problem Description: Medicare Part B reimburses physicians at a higher rate for certain services performed in their offices to account for the increased expense that physicians incur by performing services in their offices. However, when physicians perform these services in facility settings, such as an inpatient facility, Medicare reimburses the overhead expenses to the facility and the physician receives a lower reimbursement rate. An improper payment exists when physicians bill these services with an incorrect place of service based on the setting in which the services were rendered.

Here are two examples of improperly billed services.

Example 1:
An 84-year old female was admitted to an inpatient hospital stay on June 21, 2010, and was discharged on July 19, 2010.

A physician billed Current Procedural Terminology (CPT) Code 99291 (Critical Care first hour) for date of service June 23, 2010, with a place of service code 11 (Office). CPT Code 99291 has a site-of-service differential. CPT Code 99291 has a non-facility allowed amount of $260.50 and a provider paid amount of $208.40. The date of service, June 23, 2010, occurred during the inpatient hospital stay and data analysis confirms that the patient was not on a leave of absence from the hospital on that date. The correct place of service code for this service date is 21 (Inpatient Hospital).

Finding: CPT Code 99291 is adjusted to pay at the facility rate by applying the correct place of service code of 21. The allowed amount for CPT Code 99291 for the facility rate is $218.27. The new provider paid amount is $174.62. This results in a total recouped amount of $33.78.

Example 2:
A 60-year old male was admitted to an inpatient hospital stay on July 31, 2010, and discharged on August 4, 2010.

A physician billed CPT Code 90801 (Psychiatric Diagnostic Interview Examination) for date of service August 2, 2010, with a place of service code 11. CPT Code 90801 has a site-of-service differential. CPT code 90801 has a non-facility allowed amount of $159.42 and a provider paid amount of $127.54. Date of service, August 2, 2010, is during the inpatient hospital stay and data analysis confirms that the patient was not on a leave of absence from the hospital on that date. This day was not the day of admission or day of discharge. The correct place of service code for this service date is 21.

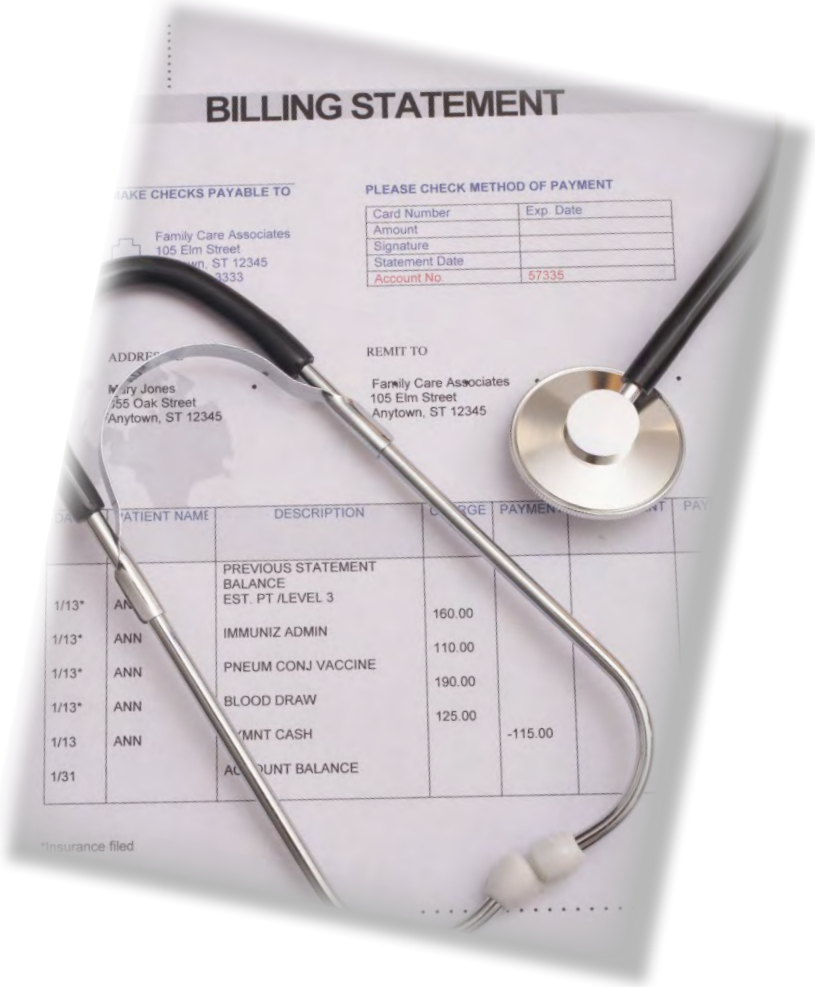
Finding: CPT Code 90801 is adjusted to pay at the facility rate by applying the correct place of service code of 21. The allowed amount for CPT Code 90801 for the facility rate is $130.94. The new provider paid amount is $104.75. This results in a total recouped amount of $22.79.

Guidance on How Providers Can Avoid These Problems:

- ✓ Physicians should be aware of the CPT/HCPCS codes with site-of-service differentials. Under the physician fee schedule, some procedures have a separate Medicare fee schedule for a physician's professional services when provided in a facility and in a non-facility. The Centers for Medicare & Medicaid Services (CMS) furnishes both fees in the Medicare Physician Fee Schedule Database (MPFSDB). Information about the Physician fee schedule may be found at **http://www.cms.gov/PhysicianFeeSched/** on the CMS website.
- ✓ CPT codes with the greatest number of improper payments based on dollars paid or number of claims paid are:
  - 99291-Critical Care first hour;
  - 85097-Bone Marrow Interpretation;
  - 96118-Neuropsychological testing; and
  - 90801-Psychiatric Diagnostic Interview Examination.
- ✓ Physicians should review the "Place of Service Code Overview," available at **http://www.cms.gov/place-of-service-codes/01_Overview.asp#TopOfPage** on the CMS website.

- ✓Physicians may wish to consult the "Medicare Claims Processing Manual," Chapter 12, paragraph 20.4.2 and Chapter 26, Section 10.5 - Place of Service Codes (POS) and Definitions, both available at **http://www.cms.gov/manuals/downloads/clm104c26.pdf** on the CMS website.

- ✓Physicians should ensure that their billing staffs use the appropriate place of service code for the service performed. A review of MLN Matters® article SE1104 should be of help to billing staff and/or billing agents regarding this issue. That article is available at **http://www.cms.gov/MLNMattersArticles/downloads/SE1104.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.

Recovery Audit Finding: Unbundling of Skilled Nursing Facility (SNF) Services Subject to Consolidated Billing (CB)

Provider Types Affected: Physicians

Problem Description:

Services are being billed separately that should be included in the SNF Consolidated Billing (SNF CB). SNF CB means that services provided during the beneficiary's stay in a SNF are bundled into one package, billed by the SNF, and paid to the SNF.

Physicians' professional services are excluded from the SNF CB, because physicians are responsible for billing for their own services.

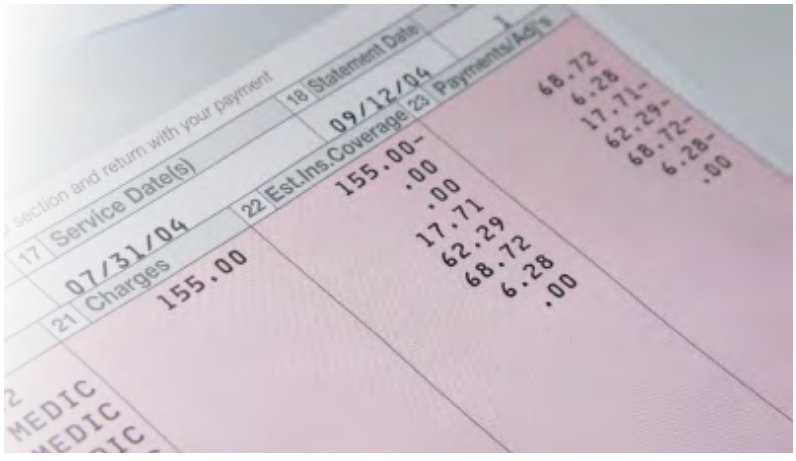
However, facility-based components of physician services (e.g., those on a salary or percentage arrangement, lessors of departments, etc., whether or not they bill patients directly) include two distinct elements - the professional component and the provider component.

- The professional component of facility-based physician's services includes services directly related to the medical care of the individual patient. SNFs cannot bill for the professional components of physician services. These must be billed under a physician provider number to the Medicare carrier or A/B MAC. The professional component is billed using Modifier 26 to indicate that the professional component of the service is being billed separately.
- The technical component (i.e., the component representing the performance of the diagnostic procedure itself) of physician services delivered to SNF inpatients are bundled into the Part A PPS and are not paid separately under Part B.

Guidance on How Providers Can Avoid These Problems:

✓SNFs, physicians, and suppliers are encouraged to review the consolidated billing requirements found in the "Medicare Claims Processing Manual," Chapter 6, SNF Inpatient Part A Billing and SNF Consolidated Billing, Sections 10, 20, 80, and 110.2, and Chapter 20, Section 211, SNF Consolidated Billing and DME Provided by DMEPOS Suppliers, available at **http://www.cms.gov/manuals/downloads/clm104c06.pdf** on the CMS website.

✓Providers should review the CPT/HCPCS codes listed in tables published by CMS that are included in SNF CB. View the latest files for these codes by going to the SNF Consolidated Billing webpage, available at **https://www.cms.gov/SNFConsolidatedBilling/71_2011Update.asp#TopOfPage** on the CMS website.



Recovery Audit Finding: **Wheelchair Unbundling**

Provider Types Affected: Durable Medical Equipment (DME) Suppliers

Problem Description: Certain wheelchair options and accessories are being billed separately. Bundling guidelines for wheelchair bases, options, and accessories indicate that certain supply codes are part of other supply codes and, as a result, are not separately payable.

Guidance on How Providers Can Avoid These Problems:

- ✓Suppliers are encouraged to review the local coverage article and the local coverage determination, which explain bundling of certain power wheelchair options and accessories. Suppliers should especially note codes E2382, E2383, E2384, and E2385, related to tires. One local coverage article number A19846 for Wheelchair Options/Accessories and Local Coverage Determination number L114682 are available at **http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx** on the CMS website. Other local coverage determinations are available at the same site.
- ✓Suppliers may also review the requirements for wheelchair bases, options and accessories in the "Centers for Medicare & Medicaid Services (CMS) Medicare National Coverage Determinations Manual," Chapter 1, Part 4, Section 280.1 - Durable Medical Equipment Reference List and Section 280.3 - Mobility Assistive Equipment (MAE), available at **http://www.cms.gov/manuals/downloads/ncd103c1_Part4.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."

Recovery Audit Finding: Improper Billing of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) During a Part A Inpatient Stay

Provider Types Affected: DMEPOS Suppliers

Problem Description: DMEPOS items are being billed separately for Medicare beneficiaries in a Part A inpatient stay. An institutional provider (e.g., a hospital) is not defined as a beneficiary's home for DMEPOS. Medicare does not make separate payment for DMEPOS when a beneficiary is in the institution during a Part A stay. The institution is expected to provide all medically necessary DMEPOS during a beneficiary's covered Part A stay.

As a result of this audit, Recovery Auditors recouped overpayments for DMEPOS items billed incorrectly during Part A inpatient stays.

Guidance on How Providers Can Avoid These Problems:

✓Providers and suppliers should review their billing practices, paying special attention to the most frequent incorrectly billed codes:

- Q0513 and Q0512 – Dispensing fees,
- E0143 – Standard folding wheeled walker, and
- J7620 – Albuterol nebulizer medication.

✓Providers and suppliers are also encouraged to review the Medicare DMEPOS billing requirements in the "Medicare Claims Processing Manual," Chapter 20, Sections 01 and 210, available at **http://www.cms.gov/manuals/downloads/clm104c20.pdf** on the CMS website.

Did you know...

The Centers for Medicare & Medicaid Services (CMS) has announced the expansion of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program to include the Round 2 and National Mail Order competitions. If you want to bid, you need to prepare now! You must make sure that your correspondence address and your authorized officials' names, Social Security numbers, and birth dates are accurate in your enrollment file at the National Supplier Clearinghouse (NSC) before registration starts. Before you submit a bid for a product category in a Competitive Bidding Area (CBA), you must have all required state licenses for that product category for each state in that CBA. It is VERY IMPORTANT that you make sure that current versions of all required licenses are in your enrollment file with the NSC BEFORE you bid. If any required licenses are expired or missing from your enrollment file, we can reject your bid and you can't get a contract.

For more information about the Medicare DMEPOS Competitive Bidding Program please visit the CMS Competitive Bidding Web site at **http://www.cms.gov/DMEPOSCompetitiveBid/** on the CMS website.

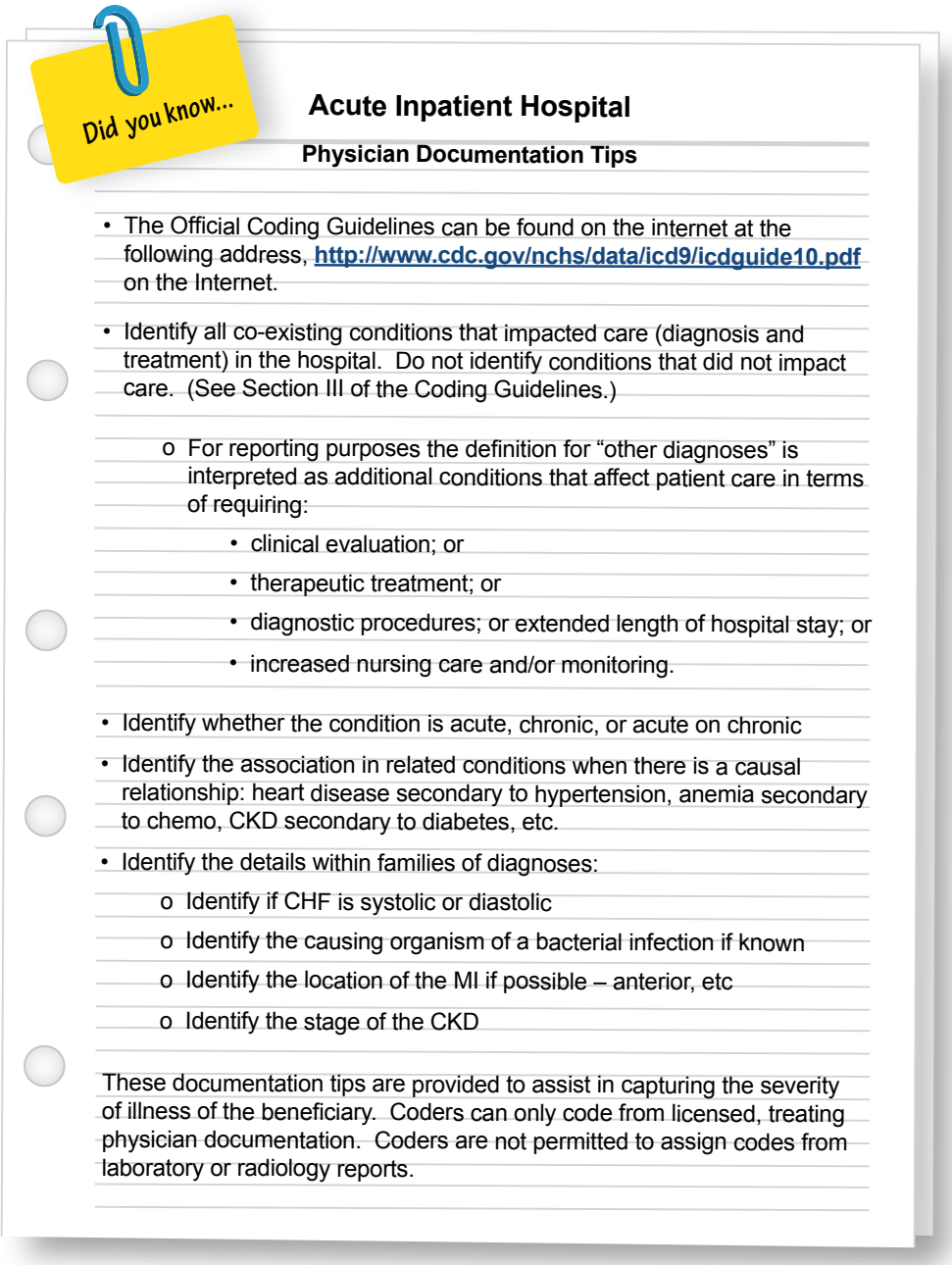
Recovery Audit Finding: Improper Billing of Clinical Social Work (CSW) Services during an Inpatient Hospital Stay

Provider Types Affected: CSWs providing services to Medicare beneficiaries in a covered Part A Inpatient Hospital stay

Problem Description: The services of Clinical Social Workers (CSW) are being billed separately that should have been included in the Inpatient Hospital Prospective Payment System (PPS) billing. CSW services rendered during inpatient hospital stays are included in the PPS payment and are not separately payable under Part B. CSW providers are expected to seek reimbursement from the facility when they provide their services to Medicare beneficiaries in a covered Part A inpatient stay.

Guidance on How Providers Can Avoid These Problems:

✓CSWs are encouraged to review Section 170 - Clinical Social Worker (CSW) Services of the "Medicare Benefit Policy Manual," Chapter 15, available at http://www.cms.gov/manuals/Downloads/bp102c15.pdf on the CMS website.



Recovery Audit Finding: Validation of Medicare Severity Diagnosis Related Group (MS-DRGs) With Ventilator Support of 96 or More Hours

Provider Types Affected: Inpatient Hospitals

Problem Description: Providers are improperly adding the correct number of Ventilator hours during Inpatient admissions OR selecting the incorrect procedure codes associated with mechanical ventilation resulting in higher reimbursement. The ventilator weaning time period (process of shifting the breathing function from the machine to the patient to allow the patient to breath on their own) should be included in the hours calculated for mechanical ventilation. Coders may have been looking at the number of days a patient was actually in the facility rather than the number of hours they were actually intubated.

Recovery Auditors validated for MS DRGs 003, 004, 207, 870, 927, and 933; principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG. The description of these DRGs includes ventilator support of 96 or more hours. As this requires a minimum ventilation period of 96 hours, claims for hospitalizations with mechanical ventilation times of less than 96 hours have been identified with one of these DRGs reported.

Here are two examples of incorrect coding for ventilation support times:

Example 1:
The patient is a 52 year old female who was admitted through the emergency room on June 21, 2009. The patient was placed on a ventilator upon admission at 4:44 A.M. and expired on June 24, 2009, at 3:45 A.M. with intubation time of 71 hours. The provider assigned procedure code 96.72 (Continuous Invasive Mechanical Ventilation for 96 Consecutive Hours or More). Documentation in the medical record supports that the patient was on mechanical ventilation approximately 71 hours.

Finding:
Based on the number of hours that the patient was on mechanical ventilation, procedure code 96.71 (Continuous Invasive Mechanical Ventilation for Less than 96 Consecutive Hours) should have been assigned. This changed the MS-DRG from 207 (Respiratory System Diagnosis with Ventilator Support 96 or More Hours) to MS-DRG 208 (Respiratory System Diagnosis with Ventilator Support Less Than 96 Hours).

Example 2:
The patient is an 84 year old male admitted through the emergency room on May 19, 2009. The patient expired on May 20, 2009. The provider assigned procedure code 96.72 (Continuous Invasive Mechanical Ventilation for 96 Consecutive Hours or More). Documentation in the medical record supports that the patient was on mechanical ventilation approximately 12 hours.

Finding:
Based on the number of hours that the patient was on mechanical ventilation, procedure code 96.71 (Continuous Invasive Mechanical Ventilation for Less than 96 Consecutive Hours) should have been assigned. This changed the MS-DRG from 870 (Septicemia or Severe Sepsis with Mechanical Ventilation 96 or More Hours) to MS-DRG 871 (Septicemia or Severe Sepsis without Mechanical Ventilation 96 or More Hours with MCC).

Guidance on How Providers Can Avoid These Problems:

- ✓ Providers should take care in using the correct code based on the documentation in the medical records. Providers may wish to review the coding clinic guidelines of when ventilation starts and ends in order to determine the correct code to use for ventilator support time. The following references may be useful:
  - ICD-9-CM Official Guidelines for Coding and Reporting, AHA Coding Clinic, ICD-9-CM 4th Q, 1991, and
  - Coding Clinic 2nd Q 1992, Pages 13-14.
- ✓ Another helpful reference is the American Hospital Association's Coding Clinic for ICD-9-CM (1984 to present). Volume 27 - 3rd Quarter – Number 3 – 2010, page 3 (Ask the Editor – Ventilator Weaning) has several questions and answers on this subject.

Recovery Audit Finding: Improper Coding of Medicare Severity-Diagnosis Related Group (MS-DRG) 853, Infectious and Parasitic Diseases with Operating Room (OR) Procedure and Major Complication or Comorbidity (MCC).

Provider Types Affected: Inpatient Hospital

Problem Description: Recovery Auditors performed coding validation on (MS-DRG) 853. For some claims they discovered that what was billed did not match the findings in the documentation.

When a patient is admitted to the hospital, MS-DRG validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record.

The following examples give reasons for adjustments to codes and MS-DRGs in order to align provider payments with Medicare and coding guidelines.

Example 1:
An 80-year-old male with past medical history of chronic renal insufficiency, congestive heart failure, diabetes mellitus, and hypertension, with a decubitus ulcer on the right foot has now developed cellulitis. He was admitted to the hospital and debridement was performed including skin, subcutaneous tissue, and muscle.

Auditor Finding:
Principal diagnosis was changed to cellulitis of the foot (ICD-CM diagnosis code 682.7 (Cellulitis and abscess of foot except toes) as this was the focus of care and the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care (Coding Guidelines for ICD-9 CM, 2007 Section II). The secondary ICD-9-CM diagnosis code 584.9 (acute renal failure, unspecified) was not supported in the medical record documentation and is changed to ICD-CM diagnosis code 585.9 (chronic kidney disease, unspecified). Also, ICD-9-CM procedure code 86.22 (excisional debridement of wound, unspecified) was changed to ICD-9-CM procedure code 83.45 (debridement of muscle, NOS). When coding multiple layer debridements of the same site, the coder should assign a code only for the deepest layer of debridement.

Resulting Action:
MS-DRG is changed from MS-DRG 853 (Infectious and parasitic diseases with OR procedure with MCC) to MS-DRG 581 (Other skin, subcutaneous tissue & breast procedure without CC/MCC), and overpayment is noted.

Example 2:
An 86-year old female presents with a necrotic heel. Patient has a medical history significant for malnutrition, pressure ulcer stage IV and III, and congestive heart failure.

Auditor Finding:
Septicemia (038.9) was coded as principal diagnosis; however, documentation does not support the coding. Documentation supports diabetic heel ulcer, uncontrolled type II diabetes (250.82) as principal diagnosis. Procedure, excisional debridement of skin (86.22), was coded; however, documentation does not support that the procedure was performed. Documentation supports non-excisional debridement (86.28) as being performed.

Action:
MS-DRG is changed from MS-DRG 853 (Infectious and Parasitic Diseases with OR procedure with MCC) to MS-DRG 637(Diabetes with MCC) and an overpayment is noted.

Guidance on How Providers Can Avoid These Problems:

When coding for an inpatient hospital stay:

- ✓The condition ultimately found to be chiefly responsible for the admission should be sequenced as the principal diagnosis;
- ✓The other diagnoses identified should represent diagnoses present during the admission that impact the stay;
- ✓The Present on Admission (POA) indicator for all diagnoses reported must be coded correctly;
- ✓The diagnostic and procedural information and the beneficiary's discharge status (as the hospital coded and reported on its claim) must match both the attending physician description and the information contained in the beneficiary's medical record;
- ✓Review the "ICD-9-CM Coding Manual" and the "ICD-9-CM Addendums and Coding Clinics" about coding guidelines on

sequencing and selection of principal diagnosis. Follow coding guidelines and Uniform Hospital Discharge Data Set (UHDDS) definitions of when to code secondary diagnosis and chronic conditions. Do not code diagnoses not documented in the record; and

- ✓The CMS Fact Sheet clarifies how to apply Present on Admission (POA) indicators to diagnosis codes for certain healthcare claims and is available at **https://www.cms.gov/MLNProducts/downloads/wPOAFactSheet.pdf** on the CMS website.

Did you know...

The results of the sixth annual Medicare Contractor Provider Satisfaction Survey (MCPSS) conducted by the Centers for Medicare & Medicaid Services (CMS) are now available. This survey offers Medicare Fee-For-Service (FFS) providers an opportunity to give CMS feedback on their satisfaction, attitudes, perceptions, and opinions about the services provided by their respective contractor. Specifically, respondents rated Medicare FFS contractors on seven key business functions of the provider-contractor relationship: Provider Inquiries, Provider Outreach and Education, Claims Processing, Appeals, Provider Enrollment, Medical Review, and Provider Audit and Reimbursement. The MCPSS was distributed to a random sample of 30,000 Medicare FFS providers and suppliers that serve Medicare beneficiaries across the country. To learn more about the results, visit **http://www.cms.hhs.gov/MCPSS** on the CMS website.

Recovery Audit Finding: Improper Coding of Coronary Bypass with Percutaneous Transluminal Coronary Angioplasty (PTCA) with Major Complications and Comorbidities (MCCs) MS-DRGs 231, 233, 235

Provider Types Affected: Inpatient Hospitals

Problem Description: The following examples give reasons for adjustments to codes and MS-DRGs in order to align provider payments with Medicare guidelines for the presence of diagnoses and to ensure diagnoses are correctly sequenced, coded, and clinically validated.

Example 1:
A 68 year old male was admitted for Coronary Artery Bypass Graft (CABG) secondary to 3 vessel Coronary Artery Disease (CAD). As indicated in the discharge summary and History and Physical (H&P), the patient was previously admitted with flash pulmonary edema and ruled in for Myocardial Infarction (MI). He was treated, optimized, and needed a period at home to take care of some personal business prior to his CABG. He was admitted for CABG, and following a CABG, secondary to 3 vessel CAD, he was discharged to home.

Auditor Finding:
A condition, ICD-9-CM Diagnosis Code 518.4 (Acute edema of lung unspecified), was coded that was not a current problem on this admission. It was not treated or evaluated.

Action:
ICD-9-CM Diagnosis Code 518.4 (Acute edema of lung unspecified) was deleted for this admission. This condition was treated on the patient's prior admission before discharge.

This coding change resulted in a change from MS-DRG 235 (Coronary bypass without cardiac cath **with MCC**) to MS-DRG 236 (Coronary bypass without cardiac cath **without MCC**) which resulted in an overpayment.

Example 2:
A 43 year old male was admitted through the Emergency Department (ED) because of chest pain that he was experiencing. He was found to have exertional angina, and he had a positive stress test. The patient was taken to the operating room where he had a 2 vessel Coronary Artery Bypass Graft (CABG) completed secondary to his Coronary Artery Disease (CAD). The patient has a history of Human Immunodeficiency Virus (HIV) and is on Highly Active Antiretroviral Therapy (HAART). After the CABG procedure, the patient remained on a ventilator for 2 hours. The patient did not have any history of Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), or asthma.

Auditor Finding:
The progress note on post operative day 1 stated there was "no apparent anesthesia related complications." The progress note by anesthesiology on post operative day 0 is the only documentation of respiratory failure. No other documentation of respiratory failure is present on the discharge summary or progress notes. Apparently, the anesthesiologist documented a need for the usual mechanical ventilation used during the procedure to continue for 2 hours after the surgery. However, the attending physician did not document respiratory failure.

Action:
The ICD-9-CM Diagnosis Code 518.5 (Pulmonary insufficiency following trauma and surgery) was deleted secondary to this being normal to post operative recovery.

This deletion resulted in a change from MS-DRG 235 (Coronary bypass without cardiac cath **with MCC**) to MS-DRG 236 (Coronary bypass without cardiac cath **without MCC**) which resulted in an overpayment.

Guidance on How Providers Can Avoid These Problems:

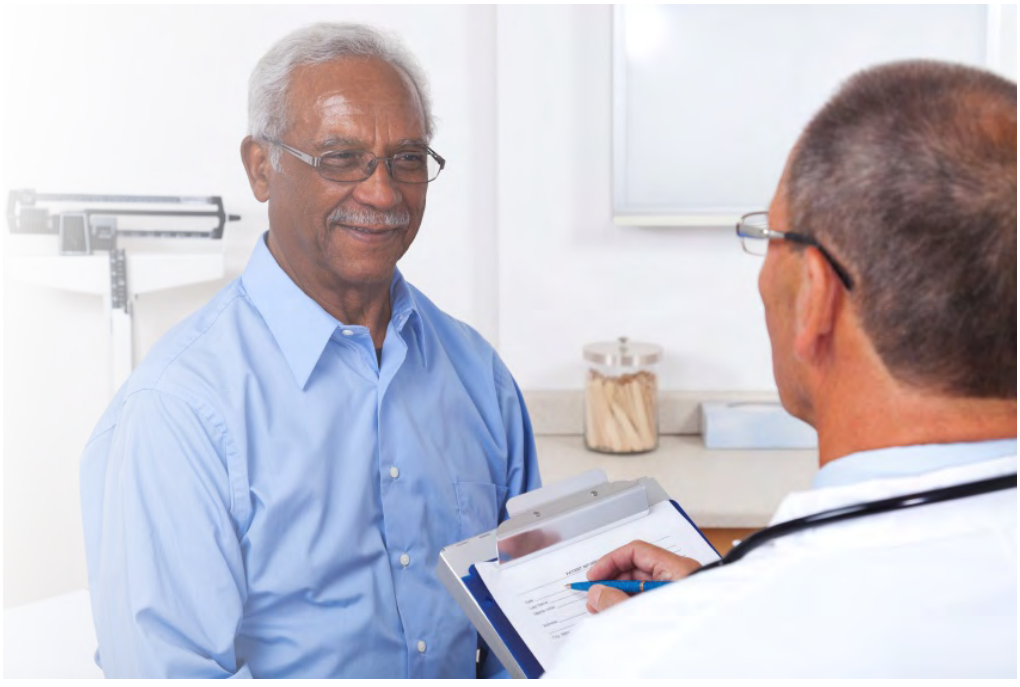
- ✓When a patient is admitted to the hospital, the health condition that (after physician assessment) is determined to be chiefly responsible as the cause for the admission should be sequenced as the principal diagnosis (coded as an MS-DRG). Review the official coding guidelines for selection of principal diagnoses and chapter specific guidelines. Refer to coding clinics for advice and guidance
- ✓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.

- ✓Review the "ICD-9-CM Coding Manual" and the "ICD-9-CM Addendums and Coding Clinics" about coding guidelines on sequencing and selection of principal diagnosis. Follow coding guidelines and Uniform Hospital Discharge Data Set (UHDDS) definitions of when to code secondary diagnosis and chronic conditions. Do not code diagnoses not documented in the record.
- ✓Review the entire medical record, including current problems on admission, admitting diagnosis, progress notes, discharge planning note, OT and PT notes and all consults. Identify documentation deficits and the need to query the physician.

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.



Recovery Audit Finding: Improper Coding of Seizures MS-DRGs 100, 101

Provider Types Affected: Inpatient Hospitals

Problem Description: Recovery Auditors performed Diagnosis Related Group (DRG) validation on principal diagnosis, secondary diagnosis, and procedures potentially affecting the Medicare Severity - DRG (MS-DRG) 100 (Seizures with Major Complications and Comorbidities (MCCs)), and MS-DRG 101 (Seizures without MCC), principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG.

The following examples give reasons for adjustments to codes and MS-DRGs in order to align provider payments with Medicare guidelines for the presence of diagnoses and to ensure diagnoses are correctly sequenced, coded, and clinically validated.

Example 1:
An eighty-two year old male was admitted through the Emergency Department (ED) after an episode of acute syncope. Following the syncopal episode, the family noted the patient had an episode of nausea, gagging, and vomiting. The ED physician impression was syncope. There was no history of a seizure episode reported by the patient's family during this syncopal episode. An electrocardiogram (EKG) performed in the ED showed a paced rhythm. The patient had a significant past medical history of cardiac issues. The physician's impression on the History and Physical (H&P) was acute syncope, etiology to be determined.

It was also noted that the patient did not feel like he was incontinent nor did he subsequently have a grand mal type seizure. The patient had a similar episode approximately 2 1/2 months ago, and at that time, there was no apparent reason for his syncopal episode. The patient showed gradual improvement in his symptoms during the hospitalization. Upon discharge, it was noted that the patient's general condition was poor, and he was not a candidate for any type of aggressive cardiac evaluation or intervention due to the patient's significant cardiac history.

Final diagnoses on discharge summary:

1. Acute syncope, probably secondary to cardiac arrhythmia;
2. Possible seizure disorder.

Auditor Finding:
The reason for admission was the syncope related to the cardiac arrhythmia, not the seizure disorder. The principal diagnosis, ICD-9-CM Diagnosis Code 780.39 (Other convulsions), was sequenced incorrectly based on the definition of principal diagnosis and the official coding guidelines on sequencing of the principal diagnosis.

Action:
The principal diagnosis was changed from ICD-9-CM Diagnosis Code 780.39 (Other convulsions) to ICD-9-CM Diagnosis Code 427.9 (Cardiac dysrhythmia unspecified).

This change in coding resulted in a change from MS-DRG 100 (Seizures with MCC) to MS-DRG 308 (Cardiac arrhythmia and conduction disorders with MCC).

Example 2:
A seventy-eight year old male with a past medical history of diabetes, Coronary Artery Disease (CAD), and Hypertension (HTN) presented to the ED after a possible syncopal episode. The patient reported that he woke up on the floor and did not recall anything prior to this event. It was noted in the discharge summary that the patient had an electroencephalogram (EEG) which was positive for seizure, and because of the fall, Physical/ Occupational Therapy (PT/OT) was ordered. It was also noted that the patient's Magnetic Resonance Imaging (MRI) was negative, and the etiology of the seizure disorder was not clear and was thought to be possibly related to dementia or small ischemic event. A Computed Tomography (CT) scan of the head showed no acute change.

Final diagnosis was seizure disorder.

- Neurology was consulted and
- Noted that it did not seem like there was any focal deficit to suggest stroke, and
- Diagnosed the patient as having seizure disorder.

The patient was treated with Keppra (levetiracetam) for his seizure disorder, and he was discharged to a Skilled Nursing Facility (SNF).

Auditor Finding:
The ICD-9-CM Diagnosis Code 434.91 (Cerebral artery occlusion unspecified with cerebral infarction) was not documented by the physician in the body of the medical record. Based on coding guidelines and the Uniform Hospital Discharge Data Set (UHDDS) definition of secondary diagnoses, this condition should not have been coded.

Action:
There was insufficient documentation to support the ICD-9-CM Diagnosis Code 434.91 (Cerebral artery occlusion unspecified with cerebral infarction), and therefore this code was deleted.

This change in coding resulted in a change from MS-DRG 100 (Seizures **with MCC**) to MS-DRG Code 101 (Seizures **without MCC**).

Guidance on How Providers Can Avoid These Problems:

- ✓The condition chiefly responsible for a patient's admission to the hospital should be sequenced as the principal diagnosis, and the other diagnoses identified should represent all CC/ MCC present during the admission that affect the stay. Code only those conditions documented by the physician. Other identified diagnoses should represent all MCCs and CCs present during the admission that affect the hospital stay. In addition, the 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 the "ICD-9-CM Coding Manual" and the "ICD-9-CM Addendums and Coding Clinics" about coding guidelines on sequencing and selection of principal diagnosis. Follow coding guidelines and Uniform Hospital Discharge Data Set (UHDDS) definitions of when to code secondary diagnosis and chronic conditions. Do not code diagnoses not documented in the record.

Recovery Audit Finding: Improper Coding of Nervous System Disorders

Provider Types Affected: Inpatient Hospitals

Problem Description: Recovery Auditors validated Medicare Severity-Diagnosis Related Groups (MS-DRG), specifically for diagnoses and procedures affecting the MS-DRG assignment for nervous system disorders.

The following examples give reasons for adjustments to codes and MS-DRGs in order to align provider payments with Medicare guidelines for the presence of diagnoses and to ensure diagnoses are correctly sequenced, coded, and clinically validated.

Example 1:
A 66 year old male, with a history of two strokes leaving him with left hemiapresis and hemiparesthesia with spasticity, was brought to the Emergency Department (ED), and later admitted with partial simple motor seizure (involuntary movements in the left face and left arm). The initial impression was that the partial seizure could be related to the old stroke. Neurology was consulted and felt that the seizures were likely the result of a lesion in the fronto-temporo-parietal area, and that the seizure was triggered by his strokes. ICD-9-CM code 345.40 (Partial epilepsy without intractable epilepsy) was assigned as the principal diagnosis.

Auditor Finding:
The auditor found an error in the sequencing of the principal diagnosis code. The code for the late effect of the Cerebrovascular Accident (CVA) should have been sequenced first, followed by an additional code for the specific late effect that was identified.

Action:
The auditor changed the principal diagnosis to ICD-9-CM code 438.89 (Other late effects of cerebrovascular disease), which changed the DRG assignment from MS-DRG 101(Seizures w/o MCC) to MS-DRG 057 (Degenerative nervous system disorders w/o MCC), resulting in an underpayment.

Example 2:
A 47 year old female with a history of alcoholism and anxiety presented to the ED after having several seizures and hallucinations. The ED impression was hallucinations, and alcohol and Xanax withdrawal; and she was admitted for hallucinations and withdrawal from benzodiazepine and alcohol. The discharge progress note contained a final diagnosis of seizure likely secondary to alcohol withdrawal.

Auditor Finding:
The auditor found incorrect sequencing of the principal diagnosis based on coding clinic guidelines. Specifically, per coding clinics 4th quarter 1985 and 1996, the withdrawal should have been sequenced as the principal diagnosis with a secondary diagnosis of seizure disorder.

Action:
The auditor corrected the sequencing error which changed the principal diagnosis from 780.39 (other convulsions) to 291.81 (alcohol withdrawal). This changed the MS-DRG from 101 (Seizures without MCC) to 894 (Alcohol/drug abuse or dependence, left Against Medical Advice (AMA); resulting in an overpayment.

Guidance on How Providers Can Avoid These Problems:

When coding for an inpatient hospital stay:

- ✓The condition ultimately found to be chiefly responsible for the admission should be sequenced as the principal diagnosis;
- ✓The other diagnoses identified should represent diagnoses present during the admission that impact the stay;
- ✓The Present on Admission (POA) indicator for all diagnoses reported must be coded correctly;
- ✓The diagnostic and procedural information and the beneficiary's discharge status (as the hospital coded and reported on its claim) must match both the attending physician description and the information contained in the beneficiary's medical record;
- ✓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; and

- ✓You might also want to review the "ICD-9-CM Coding Manual" and the "ICD-9-CM Addendums and Coding Clinics" about coding guidelines on sequencing and selection of principal diagnosis. Follow coding guidelines and Uniform Hospital Discharge Data Set (UHDDS) definitions of when to code secondary diagnosis and chronic conditions. Do not code diagnoses not documented in the record.

Did you know...

Are you short on time? The Centers for Medicare & Medicaid Services (CMS) has created podcasts from four popular ICD-10 National Provider Calls. These podcasts are perfect for use in the office, on the go in your car, or your portable media player or smart phone. Listen to all of the podcasts from a call or just the ones that fit your needs. To access the podcasts, visit the CMS Sponsored ICD-10 Teleconferences webpage located at **http://www.cms.gov/ICD10/Tel10/list.asp** on the Centers for Medicare & Medicaid Services (CMS) website.

Recovery Audit Finding: Improper Coding of Lymphoma and Non-Acute Leukemia with Major Complications/Comorbidities (MCC) MS-DRG 840

Provider Types Affected: Inpatient Hospitals

Problem Description: The following example gives reasons for adjustments to codes and MS-DRG 840 in order to align provider payments with Medicare guidelines for the presence of diagnoses and to ensure diagnoses are correctly sequenced, coded, and clinically validated.

Example 1:
A 72-year-old male with a past medical history of diffuse stage IV large cell lymphoma, cirrhosis, type 2 diabetes mellitus, benign prostatic hypertrophy, and iron deficiency anemia. presented with dehydration, fever, and weakness; and was admitted for rehydration. He was started on IV fluids and was found to have a urinary tract infection and began antibiotics. By the third hospital day, he felt subjectively improved, was able to tolerate oral feedings without nausea, vomiting or diarrhea, and was discharged. Discharge diagnoses were: 1) Diffuse Stage IV large cell lymphoma, 2) Dehydration, 3) Urinary Tract Infection, 4) Pancytopenia, and 5) Idiopathic Cirrhosis.

Auditor Finding:
While the patient's originally coded principal diagnosis was Lymphoma (ICD-9-CM code 202.80 -- Other malignant lymphomas unspecified site), Recovery Auditors found that ultimate principal diagnosis was dehydration, as this condition was the reason for admission and the focus of treatment during the hospital stay. The lymphoma was not specifically addressed during this admission, and no chemotherapy was given. Due to these findings, it was determined the principal diagnosis should have been dehydration (ICD-9-CM code 276.51--Volume depletion disorder).

Action:
Based on case review, auditors assigned dehydration (276.51) as the principal diagnosis. In addition, encephalopathy, unspecified (ICD-9-CM code 348.30--Encephalopathy unspecified) had been coded as a secondary diagnosis but was not supported by physician documentation and the auditor removed it from the claim. The resultant DRG change from MS-DRG 840 to MS-DRG 640 (Nutritional & Miscellanious Metabolic Disorders with MCC) resulted in an overpayment.

Example 2:
55 year old female with a recent diagnosis of lymphoma, who presented with three falls and worsening of right knee pain. Patient was seen by orthopedics 2 times over a two week period.

Patient in no acute distress. Extremity exam revealed large amount of swelling in right knee, that was painful to touch. Neuro exam-normal. Remainder of exam was normal. Patient was started on a dilaudid PCA, and given one dose of Neupogen and Procrit. Patient was switched to tramadol on day 2 and her pain control improved. Venous doppler of right lower extremity revealed no acute DVT, but reveal right inguinal bulky lymph nodes. Patient was also given IV fluids at a rate of 75ml/ hr and started on heart smart diet.

Auditor Finding:
Principal diagnosis is coded to 202.80 - lymphoma; however, documentation supports 338.3 - neoplasm related pain. This causes the DRG to change from DRG 840, Lymphoma and Nonacute Leukemia with MCC to DRG 947, Signs and Symptoms with MCC, and

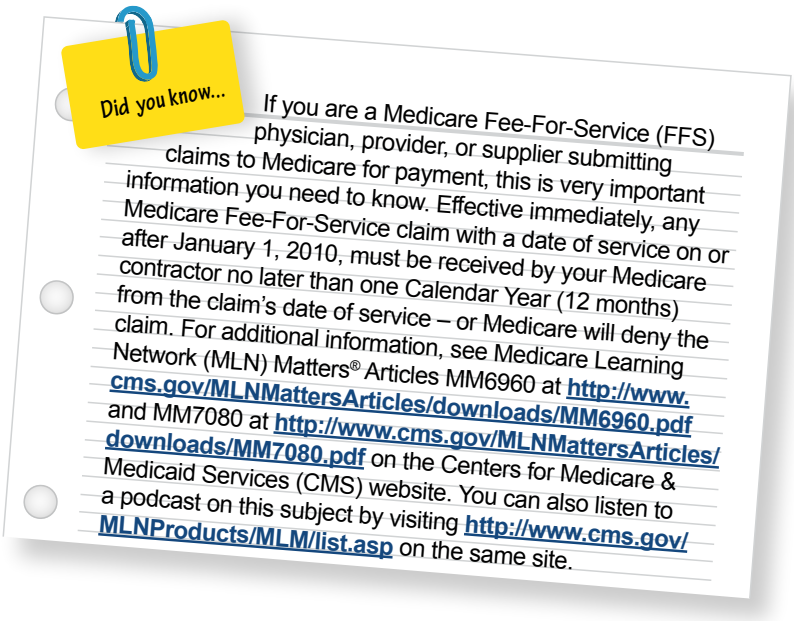
an overpayment is noted. Please refer to the Official Guidelines for Coding and Reporting for ICD-9-CM, effective 10/01/2007, Section I.C.6.a.5 regarding neoplasm related pain. Code 338.3 is assigned to pain documented as being related, associated or due to cancer, primary or secondary malignancy, or tumor. This code is assigned regardless of whether the pain is acute or chronic. After review of the medical record for DRG validation, it was determined that the main focus or thrust of treatment was pain control of right knee.

Action:
Due to these findings, it was determined the principle diagnosis should be neoplasm related pain (338.3).

Guidance on How Providers Can Avoid These Problems:

When coding for an inpatient hospital stay:

- ✓The condition ultimately found to be chiefly responsible for the admission should be sequenced as the principal diagnosis;
- ✓The other diagnoses identified should represent diagnoses present during the admission that impact the stay;
- ✓The Present on Admission (POA) indicator for all diagnoses reported must be coded correctly;
- ✓The diagnostic and procedural information and the beneficiary's discharge status (as the hospital coded and reported on its claim) must match both the attending physician description and the information contained in the beneficiary's medical record;
- ✓All medical documentation entries must be consistent with other parts of the medical record 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;
- ✓Refer to the "American Hospital Association's Coding Clinic," Second Quarter, 1988, page 9: "Determination as to whether or not dehydration should be assigned as the principal diagnosis or listed in a secondary position depends on the circumstances of the admission and the judgment of the attending physician. Dehydration is the principal diagnosis if it is the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital;" and
- ✓Review the "ICD-9-CM Coding Manual" and the "ICD-9-CM Addendums and Coding Clinics" about coding guidelines on sequencing and selection of principal diagnosis. Follow coding guidelines and Uniform Hospital Discharge Data Set (UHDDS) definitions of when to code secondary diagnosis and chronic conditions. Do not code diagnoses not documented in the record.



ICN907163 October 2011