

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



Official CMS Information for  
Medicare Fee-For-Service Providers

# Medicare Quarterly Provider Compliance Newsletter

## Guidance to Address Billing Errors



New Provider Index  
Now Available!  
See the Introduction  
section for more details

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## Archive of Previously-Issued Newsletters

This educational tool was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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# 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 on 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.

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, the Comprehensive Error Rate Testing (CERT) review contractor and other governmental organizations, such as the Office of Inspector General. This is the first issue in the third year of the newsletter.

This issue includes 7 findings identified by Recovery Auditors and one finding identified by the CERT review contractor. This educational tool 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 when dealing with the Medicare FFS program. An archive of previously-issued newsletters is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MedQtrlyCompNL\\_Archive.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MedQtrlyCompNL\\_Index.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MedQtrlyCompNL_Index.pdf) on the CMS website. In addition, a newly-enhanced index is now available that provides a listing of all Recovery Auditor and CERT Review Contractor findings from previous newsletters. The index is customized by specific provider types to help providers quickly find and learn about common billing and claim review issues that impact them directly. For more information, visit the newsletter archive at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyCompNL\\_Archive.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyCompNL_Archive.pdf) on the CMS website.

## Comprehensive Error Rate Testing (CERT) Finding: Power Wheelchairs

**Provider Types Affected:** Physicians and Durable Medical Equipment Suppliers

**Background:** The Comprehensive Error Rate Testing (CERT) program reviews of power wheelchair claims have consistently yielded high improper payment rates. Based on these findings, the Centers for Medicare & Medicaid Services (CMS) conducted a special study of power wheelchair claims. Improper payment rate reduction targets will be developed using the results of this report and future reports. The power wheelchair categories studied include:

- Group 1: Standard, portable, sling/solid seat/back, capacity up to 300 lbs. (**K0813**)
- Group 2: Standard, portable, captain's chair, capacity up to 300 lbs. (**K0821**)
- Group 2: Standard, sling/solid seat/back, capacity up to 300 lbs. (**K0822**)
- Group 2: Standard, captain's chair, capacity up to 300 lbs. (**K0823**)
- Group 2: Heavy duty, sling/solid seat/back, capacity 301 to 450 lbs. (**K0824**)
- Group 2: Heavy duty, captain's chair, capacity 301 to 450 lbs. (**K0825**)
- Group 3: Heavy duty, sling/solid seat back, capacity 301 to 450 lbs. (**K0850**)
- Group 3: Very heavy duty, single power option, sling/solid seat/back, capacity 301 to 450 lbs. (**K0861**)

The following discussion presents:

1. power wheelchair coverage requirements,
2. common causes of improper payments for power wheelchair claims,
3. examples of power wheelchair claim errors, and
4. steps providers and suppliers can follow to avoid these errors.

### **Power Wheelchair Requirements:**

Medicare provides coverage for wheelchairs and scooters under its Part B Durable Medical Equipment (DME) benefit.

- Medicare will only pay for a covered power wheelchair if a physician or treating practitioner conducts a face-to-face examination of the beneficiary and writes a prescription for the item.
- A power wheelchair may be prescribed if a beneficiary cannot use a cane, walker or manually operated wheelchair to effectively perform Mobility-Related Activities of Daily Living (MRADLs) in the home.
- The beneficiary must also be able to safely and effectively use the power wheelchair in the home.

Suppliers must meet all documentation requirements included in the power wheelchair Local Coverage Determinations (LCD) issued by the DME Medicare Administrative Contractors (MACs) in order to receive Medicare

payment for a power wheelchair. The LCD requires that suppliers maintain a variety of documents that support the beneficiary's need for, and the appropriateness of, the provided power wheelchair.

### **Improper Payments by Type of Error: Insufficient Documentation Error**

The majority of power wheelchair errors were due to insufficient documentation errors. Insufficient documentation errors occur when the medical documentation submitted is inadequate to support payment for the services billed. In other words, the medical reviewers could not conclude that some of the allowed services were actually provided, were provided at the level billed, and/or were medically necessary. Claims are also placed into this category when a specific documentation element that is required as a condition of payment is missing. This may include a physician signature on an order, or a form that is required to be completed in its entirety.

- Most insufficient documentation errors resulted from claims in which there were **incomplete or no face-to-face examinations or mobility evaluations** for the power wheelchair billed.
- The second most frequent reason for insufficient documentation errors was for claims in which the **seven element order form was not complete in that any one of the seven items is missing**.

**Here is an example of an insufficient documentation error:**

Mr. Smith’s medical record showed that she had a physical condition that led to leg weakness and falls at home. However, the face-to-face examination did not address why her mobility limitations could not be sufficiently and safely resolved by the use of an appropriately fitted cane or walker. This claim was scored as an improper payment due to an insufficient documentation error.

**Improper Payments by Type of Error: Medical Necessity Error**

A small proportion of claims in this special study were categorized as medical necessity errors. Medical necessity errors occur when the medical reviewers receive adequate documentation from the medical records submitted to make an informed decision that the services billed were not medically necessary based upon Medicare coverage policies. A common reason for medical necessity errors was that the face-to-face examination did not support that the beneficiary’s condition required the use of a power wheelchair, such as when they were able to safely ambulate with the use of a walker.

**Here is an example of a medical necessity error:**

Ms. Jones’ medical record showed that she had a physical condition that led to leg weakness and falls at home. However, the face-to-face examination mentioned that she was safely ambulating around the house with the use of an appropriately fitted walker, but that she wanted the power wheelchair so that she could travel around the neighborhood. This claim was scored as a medical necessity error.

**Guidance on How Providers Can Avoid These Problems:**

- ✓ Review the MLN fact sheet titled “Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements,” which provides education on Medicare coverage of PMDs and describes common CERT Program errors related to PMDs. It also provides a checklist of the documentation needed to support a claim submitted to Medicare for PMDs. This fact sheet is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/PMD\\_DocCvg\\_FactSheet\\_ICN905063.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/PMD_DocCvg_FactSheet_ICN905063.pdf) on the CMS website.
- ✓ Review the Durable Medical Equipment (DME) Center web page at <http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html> on the CMS website. This web page provides helpful resources and information about DME, including PMDs.

**Other DME Resources on the Internet**

- ✓ Review the "Medicare Benefit Processing Manual," Chapter 15 – Covered Medical and Other Health Services at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf> on the CMS website.
- ✓ Review the "Medicare Claims Processing Manual," Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf> on the CMS website.

**There are four DME MAC Suppliers.** You can view their websites at the following links:

- ✓ Cigna Government Services is available at <http://www.cgsmedicare.com/jc/index.html> on the Internet.
- ✓ National Government Services is available at <http://www.ngsmedicare.com/wps/portal/ngsmedicare/home> on the Internet.
- ✓ National Heritage Insurance Company (NHIC) is available at [http://www.medicarenhic.com/cpt\\_agree.shtml](http://www.medicarenhic.com/cpt_agree.shtml) on the Internet.
- ✓ Noridian Administrative Services is available at <https://www.noridianmedicare.com/dme/> on the Internet.



## Recovery Audit Finding: Major Joint Replacement or Re-attachment with Major Complication or Comorbidity (MCC)

**Provider Types Affected:** Inpatient Hospitals

**Problem Description:** Major joint replacement or reattachment is one of the Centers for Medicare & Medicaid Services (CMS) top volume Diagnosis Related Groups (DRG). The Uniform Hospital Discharge Data Set (UHDDS) guidelines for reporting of other (secondary) diagnosis defines other diagnoses as all conditions that coexist at the time of admission, develop subsequently, or affect the treatment received and/or the length of stay. Exclude any diagnoses that relate to an earlier episode and have no bearing on the current hospital stay.

This review was intended to validate for MS-DRG 469, Major Joint Replacement or Reattachment of Lower Extremity with MCC, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG. Reviewers determined whether the principal diagnosis and all complicating conditions (CC) and major complicating conditions (MCC) were actually present, correctly sequenced, coded and clinically validated. When a patient is admitted to the hospital, the condition established after study found to be chiefly responsible for occasioning the admission to the hospital should be sequenced as the principal diagnosis. The other diagnoses identified should represent all MCC/CC present during the admission that affects the stay. The Present on Admission (POA) indicator for all diagnoses reported must be coded correctly.

**Findings:** Overall findings were the removal of the secondary diagnoses (MCC) that resulted in MS-DRG changes.

**Example 1 Admitting diagnosis:** *Knee pain.* A 78-year-old female presented for an elective procedure on her right knee. On admission, it was noted that she has severe and painful degenerative damage of the right knee and is being admitted for total right knee replacement. The patient has a history of hypertension, degenerative joint disease of multiple sites, and moderate protein malnutrition. Nutritional consult was obtained.

Patient underwent a total right knee replacement and developed acute blood loss anemia postoperatively, which was treated with blood transfusion. Physical therapy was started and the patient was discharged to rehabilitation.

**Discharge summary:** Patient had a total knee replacement on the right knee. Patient did well postoperatively and was started on physical therapy. Discharge to the rehab unit.

**Finding and code correction:** The provider coded the protein malnutrition as International Classification of Diseases, Clinical Modification (ICD-9-CM) code 260 - Kwashiorkor, which is classified as a MCC. According to coding clinic third quarter 2009, protein malnutrition should be coded to category 263. Therefore, 260 - Kwashiorkor was changed to 263.0 - Moderate malnutrition, which is classified as a non-CC. This change in diagnosis

code resulted in an MS-DRG change from 469 - Major Joint Replacement or Reattachment of Lower Extremity with MCC to 470 - Major Joint Replacement or Reattachment of Lower Extremity without MCC. These changes resulted in an overpayment.

**Coding Clinic:** *Third Quarter, 2009, p. 6:* The provider documented "malnutrition" in the final diagnostic statement on the discharge summary. He was queried to further specify the type of malnutrition. His response was "moderate protein malnutrition."

It is not appropriate to assign codes for both moderate malnutrition (263.0) and protein malnutrition (260) to show both types. Assign only code 263.0, Malnutrition of moderate degree, for moderate protein malnutrition. This code category includes protein-calorie malnutrition. Code 260, Kwashiorkor, is not appropriate since the provider did not specifically document this condition. Kwashiorkor syndrome is a condition that is caused by severe protein deficiency that is usually seen in some underdeveloped areas in Africa and Central America. However, it is extremely rare in the United States. The National Center for Health Statistics (NCHS) is considering a proposal to revise the index entries under mild and moderate protein malnutrition in order to provide clearer direction to the coder.

**Example 2 Admitting diagnosis:** *Hip pain.* A 66-year-old male was found to have a pathological right hip fracture. After extensive work-up with radiological exams, it was noted that the patient had a pathological

subcapital fracture of the right hip that is four weeks old.

**History and Physical:** The patient presented for treatment of the fracture with an arthroplasty with prosthetic implant. Patient has an extensive past medical history including lung malignancy with metastatic disease to the liver and bones, chronic obstructive pulmonary disease, coronary artery disease, hypertension, hyperlipidemia. Patient's past medical history is significant for multiple pulmonary emboli with placement of an intravenous catheter (IVC) filter approximately four years ago. Patient is on Coumadin. All radiology reports are negative for acute pulmonary embolism on this admission.

**Preoperative diagnosis:** Subcapital fracture right hip. **Postoperative diagnosis:** Same (four weeks old).

**Procedure performed:** Arthroplasty with Zimmer unipolar prosthesis/13mm stem, 43 mm head, 0 degree neck.

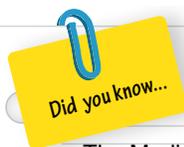
**Discharge summary:** Patient was treated surgically for a pathological right hip fracture with arthroscopy and replacement of the hip joint. Final diagnosis is pathological right hip fracture. History of lung malignancy with metastasis to the liver and bone; tumor induced Syndrome of Inappropriate Antidiuretic Hormone Secretion (SIADH); hypophosphatemia; multiple pulmonary emboli and was being maintained on Coumadin and has an IVC filter in place. Patient was discharged to skilled nursing facility.

**Finding and code correction:** The secondary diagnosis of 415.19 - Pulmonary Embolism and Infarction not elsewhere classified (NEC), which is classified as a MCC, was changed to 416.2 - Chronic Pulmonary Embolism, which is classified as a CC. The patient did not have an acute pulmonary embolism during this admission, therefore it was inappropriate to report code 415.19. This secondary diagnosis change resulted in an MS-DRG change from 469 - Major Joint Replacement or Reattachment of Lower Extremity with MCC to 470 - Major Joint Replacement or Reattachment of Lower Extremity without MCC. These changes resulted in an overpayment.

**Coding clinic, Fourth Quarter 2009, p.85-8:** Effective October 1, 2009, a new code (416.2) has been created to describe chronic pulmonary embolism to distinguish between patients who are being treated for an acute pulmonary embolism and patients with chronic pulmonary embolism who are being maintained on anticoagulant therapy for an extended period of time. Previously, the classification did not differentiate between acute and chronic pulmonary embolism.

## Guidance on How Providers Can Avoid These Problems

- ✓ Follow all ICD-9-CM coding guidelines and coding clinics related to malnutrition. Ask the provider for more information if a condition is unclear or unlikely.
- ✓ Ensure that coders stay up-to-date and follow all coding guidelines and coding clinics rules related to coding chronic conditions.
- ✓ Review the MLN Matters® Special Edition Article, SE1236, at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1236.pdf> for more information on documenting medical necessity of major joint replacement (hip and knee).



- The Medicare Learning Network® (MLN) has released a new package of products designed to educate physicians and other Medicare and Medicaid providers about medical identity theft and strategies for addressing it. These products include a web-based training course that is approved for Continuing Education (CE) and Continuing Medical Education (CME) credit. For more information, visit the MLN Provider Compliance web page at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html> and click on the 'Medicaid Program Integrity: Safeguarding Your Medical Identity Educational Products' link under 'Downloads' at the bottom of the page.

## Recovery Audit Finding: Medical Necessity: Acute Inpatient Admission Respiratory Conditions

**Provider Types Affected:** Inpatient Hospitals

**Problem Description:** The Recovery Auditors reviewed documentation to validate the medical necessity of short stay, uncomplicated admissions. Medicare only pays for inpatient hospital services that are medically necessary for the setting billed and that are coded correctly. For this report, medical documentation was reviewed to determine that the services were medically necessary and were billed correctly for the Medicare Severity-Diagnosis Related Groups (MS DRG) in the following Table:

**Table: MS DRGs and Definitions Included in this Review**

MS DRG	Definition
177, 178, 179	Respiratory infections and inflammations with major complication or comorbidity (w MCC); with complication or comorbidity (w CC); without CC/MCC (w/o CC/MCC)
180	Respiratory neoplasms w MCC
190, 191, 192	Chronic obstructive pulmonary disease w MCC; w CC; w/o CC/MCC
193, 194, 195	Simple pneumonia & pleurisy w MCC; w CC; w/o CC/MCC
196, 197, 198	Interstitial lung disease w MCC; w CC; w/o CC/MCC
202, 203	Bronchitis and asthma w CC/ MCC; w/o CC/MCC
204	Respiratory signs & symptoms
205, 206	Other respiratory system diagnoses w MCC; w/o MCC

The auditors also reviewed documentation for DRG Validation for MS DRGs 195 (simple pneumonia and pleurisy w/o CC/MCC), 196 (interstitial lung disease w MCC) and 197 (interstitial lung disease w CC). This requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, match both the attending physician description and the information contained in the beneficiary's medical record. Auditors validated for MS DRG, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG.

After patients met medical necessity, the auditors examined the medical record to validate MS DRGs 195, 196 and 197. The review was conducted to see if the medical record documentation supported the DRG's assigned. The medical record was reviewed by the Recovery Auditor Medical Director.

**General Findings:** The Recovery Auditors found that the requirements for inpatient status were not met.

- ✓ The "Medicare Program Integrity Manual," Chapter 6, Section 6.5.2.A, states that inpatient care rather than outpatient care is required only if the patient's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. This manual section is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf> on the CMS website.

- ✓ The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark; that is, they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment. It can only be made after the physician has considered a number of factors. These factors include the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.

- ✓ Consider the following factors when making the decision to admit the patient:
  - The severity of the signs and symptoms exhibited by the patient;
  - The medical predictability of something adverse happening to the patient;
  - The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and

- The availability of diagnostic procedures at the time when and at the location where the patient presents.

Observation care is a well defined set of specific, clinically-appropriate services. It may include ongoing short term treatment, assessment, and reassessment before a decision is made regarding whether patients will require further treatment as hospital inpatients or if they can be discharged from the hospital.

Observation services are commonly ordered for patients who present to the Emergency Department and then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

For more information, review the "Medical Policy Benefit Manual," Chapter 6 - Hospital Services Covered under Part B at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf> on the CMS website.

### Examples of Inappropriate Hospital Admissions for Patients with Respiratory Diagnoses:

**Example 1:** A 59-year-old male presented to the Emergency Department with complaint of chest pain. The chest pain did not radiate and there were no associated symptoms. Past medical history was significant for coronary artery disease and coronary stents. Vital signs were blood pressure 105/72, pulse 79, temperature 98.2, respirations 20 and pulse ox of 97% on room air. The exam revealed clear lung sounds bilaterally. The white blood cell count was 7.0. The EKG had no acute changes and the chest x-ray was normal. The initial cardiac enzymes were negative.

*History and Physical* – 59-year-old male with sudden onset of chest pain, described as sharp, stabbing, with no radiation, nausea, vomiting, or diaphoresis. Patient reportedly ran out of sublingual nitroglycerin.

*Past Medical History:* CAD with stents one year ago.

*Review of Systems:* chest pain, no orthopnea, no paroxysmal nocturnal dyspnea, Non-productive cough.

*Physical Examination:* 105/72, 79, 98.2, 20, 97% on room air. EKG normal sinus rhythm, with no acute ST-T wave changes. Cardiac isoenzymes negative. Chest X-Ray- Chronic Obstructive Pulmonary Disease (COPD) changes, no acute infiltrates. Heart rate regular rhythm, no wheezing, but slight rhonchi. No edema.

The patient was treated with sublingual nitroglycerin, oxygen, aspirin, pain medication, intravenous steroids and one nebulizer treatment. His chest pain improved. He was placed into the hospital for chest pain and mild chronic obstructive pulmonary disease and bronchitis.

*Admitting diagnosis:* Mild COPD 2. Costochondritis

*Discharge Summary:* The patient was treated with sublingual nitroglycerin, without resolution of chest pain. Patient also treated with intravenous morphine without relief. The chest pain was finally relieved with intravenous ketorolac. The patient improved and was discharged the following day, with follow-up with primary care provider as needed.

**Finding:** Based on the severity of signs and symptoms and the potential for adverse events, these services could have been billed at the appropriate **outpatient level of care**.

**Example 2:** A 73-year-old male with history of lung cancer and emphysema was admitted to the hospital from clinic after an esophagogastroduodenoscopy (EGD) showed a gastroesophageal junction mucosal abnormality with retained food, mild esophagitis and duodenal ulcerations. The patient had hypoxemia with subtle shortness of breath postoperatively and received a dose of Solumedrol.

*History and Physical* – 73-year-old male with difficulty holding food down. Patient reported when he swallows, he feels like it gets stuck in center of his chest. Patient had esophagogastroduodenoscopy (EGD), which revealed retained food in the esophagus and duodenitis. Patient reportedly developed hypoxemia after the EGD. Therefore, he was placed in the hospital for intravenous Solu-Medrol, and IV Protonix.

*Past Medical History:* lung cancer, emphysema, Benign Prostrate Hypertrophy, chronic kidney disease, diastolic dysfunction.

*Review of Systems:* no fevers.

*Physical Examination:* NAD, 110/70, pulse ox 93% room air, and respiratory rate not documented. Mild to moderate wheezing noted, treated with one nebulizer treatment. Chest X-Ray right hilar mass, and lung consolidative pneumonia (no treatment rendered).

He was placed into the hospital for a workup.

*Admission diagnoses:* 1. Dysphagia 2. Bronchospasm status post EGD.

The patient denied nausea, vomiting, fever, chills or any other constitutional symptoms. The physician's plan was to administer a dose of IV

Proton pump inhibitor and an anti-inflammatory regimen. The patient was discharged to home the next day with addition of Prednisone to his medications.

*Discharge summary:* 73 year old male with dysphagia, who had an EGD, revealing retained food, duodenitis, with biopsies taken for possible cancer. Patient developed wheezing after the EGD, and decrease in pulse ox, therefore placed in the hospital for IV Solu-Medrol and IV protonix. Patient symptoms resolved after the initial nebulizer treatment, but placed in hospital for monitoring. Patient was discharged the following day, with PrevPac and prednisone for three days.

**Finding:** Based on the severity of signs and symptoms and the potential for adverse events, these services could have been billed at the appropriate **outpatient level of care**.

### Guidance on How Providers Can Avoid These Problems:

- ✓ Provider and hospital associations should educate physicians and hospital staff regarding levels of care. This education should include information on the criteria for full inpatient admission versus observation status and the appropriate use of both.
- ✓ Review the "Medicare Program Integrity Manual," Chapter 6, which describes the rationale for inpatient care rather than outpatient care. This manual chapter is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf> on the CMS website.
- ✓ Document medical treatment in the patient's medical record using appropriate documentation standards. Review the treatments rendered and assess appropriateness of inpatient status.



#### Did you know...

Did the medical records support the service billed on your claim selected by the CERT, Recovery Auditors (RA), or Medicare contractor(s), but you still received an error? Were some of the documents missing from your original response to the documentation request which caused the claim to be in error? If you receive an error on a claim selected by the CERT, RA or Medicare contractor, please review the medical records and determine if you agree with the results. If you disagree, you can appeal with your local Medicare contractor using the normal appeal process. Visit your local Medicare contractor's website for any appeal forms and appeal process. To find your local Medicare contractors contact information and website address, please visit <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip> on the CMS website. For more information about the Medicare Part A and Part B administrative appeals process, please refer to the Medicare Learning Network® brochure "The Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers".

## Recovery Audit Finding: Medical Necessity: Other Skin, Subcutaneous Tissue & Breast Procedures DRG 581

**Provider Types Affected:** Inpatient Hospitals and Physicians

**Problem Description:** The Recovery Auditors reviewed claims to identify whether medical services were rendered in an inappropriate facility setting. The definition of medical necessity requires that review of the medical record indicates that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay. The beneficiary must demonstrate signs and symptoms severe enough to warrant the need for medical care. He or she must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

In the claims described below, both patients had outpatient diagnosis of breast carcinoma, based on biopsies performed with ultrasound guidance. The patients had pre-operative anesthesia clearance prior to the scheduled operative dates. The patients also had no documented surgical complications or anesthesia related complications during the surgery and during the post-operative phase. Due to these factors, these procedures could have safely been performed and billed as an observational level of care.

The Recovery Auditors reviewed documentation to validate the medical necessity of short stay, uncomplicated admissions. Medicare only pays for inpatient hospital services that are medically necessary for the setting billed and

that are coded correctly. Medical documentation was reviewed to determine that the services were medically necessary and was billed correctly for MS-DRG 581.

The Recovery Auditors also reviewed documentation for DRG Validation for MS DRG 581 requiring 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. Reviewers validated the MS-DRG, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG. The medical record was reviewed by the Recovery Auditor Medical Director.

The procedures performed are published in the 2011 Centers for Medicare & Medicaid Services (CMS) Hospital Outpatient Prospective Payment System Ambulatory Payment Classification (OPPS APC) list. This list is updated and published at least annually by CMS. It indicates whether procedures are covered by Medicare Part A as outpatient procedures (same-day or overnight stays) versus inpatient only procedures. Performing physicians must document clinical rationale of clinically significant post-operative complications in accordance with appropriate CMS guidelines to support the need for a level of care beyond that covered by

CMS regulations and guidelines. The current list is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Transmittals.html> on the CMS website.

**Findings and Demand:** Review of the medical records failed to yield documentation of post-procedural complications warranting an increased level of care beyond the post-op level of care covered by CMS in accordance with published guidelines.

An observational level of care was appropriate for these patients, with further decision-making to be based upon treatment response versus clinical decline with an associated need for an increased level of care. The record did not demonstrate that the patient required inpatient-level services at any time during the short stay.

### **Example 1 Admitting diagnosis:**

1. Left breast invasive ductal carcinoma
2. Hypertension
3. Hypothyroid
4. Diabetes
5. Arthritis
6. Hypercholesterolemia.

The patient is a 65-year-old female with a history of invasive ductal carcinoma, grade 2, moderately well-differentiated, confirmed by biopsy. She presented to the hospital for left breast total mastectomy and left sentinel node biopsy. Patient had a recent screening mammogram which demonstrated a 20 mm. density in the medial left breast at the nine o'clock position. A follow-up ultrasound

was performed, with a biopsy, and confirmed invasive ductal carcinoma.

**Past medical history (PMH):**

hypertension, hypothyroidism, diabetes, arthritis, hyperlipidemia.

**Review of Systems (ROS):** as per history of present illness (HPI).

**Physical Exam (PE):** Vital signs stable; breast exam- nipples were everted, no discharge. There is an irregular firm region at the 9 o'clock position of the left breast. The right breast is normal. No axillary masses appreciated.

**Operative note:** The patient underwent a left total mastectomy, sentinel node biopsy, left axilla; and injection of dermis, left breast, with technetium-labeled sulfur colloid. The operative note states that the patient was Mallampati Class I, general anesthesia was given. Patient had a left breast total mastectomy, with left axilla sentinel node biopsy. Estimated blood loss was less than 50 mls. Patient had no documented complications on the operative report. Patient was taken to the recovery room and extubated without any complications. Patient was noted to have no anesthesia complications and was tolerating oral hydration in the recovery room. No apparent complications were noted. The patient was discharged home with drain care instructions.

**Discharge summary:** A 65-year-old female who underwent an elective left breast total mastectomy with sentinel node biopsy. Patient had an uncomplicated operative and postoperative course. Patient was to follow-up at the office for treatment option discussion. Patient was discharged the following day.

**Finding:** Based on the severity of signs and symptoms and the potential for adverse events, these services could have been billed at the appropriate outpatient level of care.

**Example 2 Admitting diagnosis:**

1. Right breast cancer. This is a 69-year-old female with right breast cancer who presented for a scheduled procedure. She underwent a right mastectomy and sentinel lymph node biopsy, as planned. There were no documented complications. Post-procedure care was provided in accordance with standard protocol for these procedures. Pain was managed postoperatively with oral medication. The patient's dressing was dry and intact. She was discharged to home in good condition the next day.

**History and Physical:** 69-year-old female who presented to the hospital for a scheduled right mastectomy and Sentinel lymph node biopsy. Patient had her right breast cancer diagnosed but ultrasound guided biopsy.

**PMH:** hypertension, arthritis.

**ROS:** as per HPI.

**PE:** Vital signs stable, breast exam- no palpable masses or axillary lymph nodes were appreciated.

**Operative note:** Patient had a right total mastectomy, with three lymph node biopsies. Estimated blood loss was 25 mls. Patient had no documented complications during the surgery, and an uncomplicated postoperative course. Patient was taken to the recovery room and extubated without complications. Patient was tolerating oral fluids in the recovery room.

**Discharge summary:** 69-year-old female recently diagnosed with right breast cancer. Patient underwent a right mastectomy and right sentinel lymph node biopsy. Patient had an uncomplicated surgical course, as well as an uncomplicated postoperative course. Patient was discharged home the following day with follow-up with the surgeon in one week.



**Finding:** There is no physician order for an inpatient admission. The physician's order was for outpatient. Therefore, a billing error occurred.

### Guidance on How Providers Can Avoid These Problems:

- ✓ Physicians and hospitals must stay up-to-date on hospital admission levels of care and understand full inpatient admission criteria versus observation status and the appropriate use of both. Physicians and hospital associations should educate their members on levels of care.
- ✓ Physicians and providers should meet appropriate documentation standards.
- ✓ In the instance of no order to hospitalize, the coder must verify if the physician intended to make the patient inpatient versus outpatient status following the procedure.
- ✓ Review the "Medicare Benefit Policy Manual," Chapter 1 - Inpatient Hospital Services Covered under Part A, at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf> on the CMS website.

Review the "Medicare Benefit Policy Manual," Chapter 6 - Hospital Services Covered Under Part B at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf> on the CMS website.

- ✓ The Hospital OPPTS web page contains detailed information on PPS matters and is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> on the CMS website.



## Recovery Audit Finding: Outpatient within Inpatient Stay

### Provider Types Affected: Inpatient Hospitals

**Problem Description:** Recovery Auditors conducted an automated review for all Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes not specifically excluded (e.g., preventive codes like influenza vaccine). The review identified overpayments of outpatient services billed and reimbursed while the patient was within an inpatient stay paid under the Inpatient Prospective Payment System (IPPS). Outpatient services can be provided by the same or different provider.

**Note:** Per the "Medicare Claims Processing Manual," the preventive codes for flu vaccine and its administration (90655, 90656, 90657, 90658, 90659, 90660, G0008), pneumococcal vaccine (90669, 90732, G0009), hepatitis vaccine and its administration (90740, 90743, 90744, 90746, 90747, G0010), screening mammography (77052, 77057, and G0202) reported on the date of discharge are specifically excluded.

**Finding and demand:** The reimbursement of outpatient services within a PPS hospital stay was identified as a duplicate payment and is an overpayment.

Below are two examples of duplicate billing for inpatient and outpatient claims.

**Example 1:** An IPPS inpatient paid claim for dates of service 10/6/2010-10/29/2010 and an outpatient claim (same facility) for date of service 10/11/2010, for the same beneficiary with laboratory CPT codes with a payment of \$269.80.

The outpatient claim was identified as a duplicate payment because the laboratory charges fell within the inpatient stay and these services are included in the MS-DRG payment made on the inpatient claim.

**Example 2:** An IPPS inpatient paid claim for dates of service 11/7/2010-11/13/2010 and an outpatient claim (different facility) for date of service 11/11/2010, for the same beneficiary with laboratory CPT codes and a surgical procedure endoscopic retrograde cholangiopancreatography (ERCP) with a payment of \$2132.02.

The outpatient claim was identified as a duplicate payment because the laboratory and surgical procedure charges fell within the inpatient stay and these services are included in the MS-DRG payment made on the inpatient claim.

### Guidance on How Providers Can Avoid These Problems:

- ✓ Hospitals should have processes in place when referring a patient out for a procedure with the expectation that the patient will be returning to the admitting facility. When transferring a patient for a procedure with the intent the patient will return to the admitting facility on the same day, the hospital should confirm that all medical records accompany the patient to the referred facility. This should ensure that the outpatient entity is aware that billing for the patient falls under the inpatient PPS rules.
- ✓ Hospitals should ensure that billing coders are familiar with those codes included in the IPPS.
- ✓ Review the "Medicare Claims Processing Manual," Chapter 1, Section 120, Detection of Duplicate Claims at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf> on the CMS website.
- ✓ Review the "Medicare Claims Processing Manual," Chapter 3, Section 40.3.1, at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf> on the CMS website.

## Recovery Audit Finding: Place of Service Coding for Physician Services in an Outpatient Setting

**Provider Types Affected:** Physicians

**Problem Description:** Physicians are incorrectly reporting office place of service (POS) code of 11 when services are provided in an outpatient hospital setting, which is POS code 22. This results in overpayments to the physicians. Through data analysis (automated review) by the Recovery Auditors, an outpatient claim is identified reporting the same surgical Current Procedural Terminology (CPT) code for the same patient and same date of service as a professional claim with a reported POS (11) office.

To account for the increased expense that physicians incur by performing services in their offices, Medicare Part B reimburses physicians at a higher rate for surgical procedures performed in their offices. However, when physicians perform these services in facility settings such as an outpatient 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 POS based on the setting in which the services were rendered.

All surgical CPT codes (10000-60000) were reviewed, with CPT Codes in the Integumentary System (10000 series) having the greatest number of improper payments.

Below are two examples of billing with an incorrect POS.

**Example 1:** An 84-year-old female has an outpatient claim paid for services provided on 3/7/2008. Reported on the outpatient claim is CPT code 62311- Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast of diagnostic or therapeutic substance(s), epidural or subarachnoid; lumbar, sacral.

A professional claim is identified for the same patient, same date of service, and same CPT code 62311 with POS code of 11 (office).

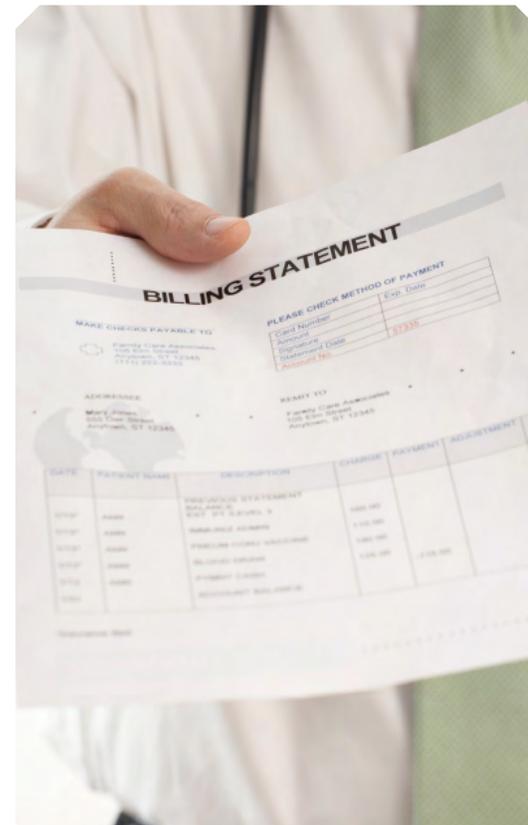
**Finding and corrected billing:** The correct POS for this date of service is Outpatient Hospital (22). CPT code 62311 is adjusted to pay at the facility rate by applying the correct POS code 22 and the overpayment is recovered.

**Example 2:** An 88-year-old female has an outpatient claim paid for services provided on 3/12/2008. Reported on the outpatient claim is CPT code 11100 - Biopsy of Skin, single lesion. A professional claim is identified for the same patient, same date of service, and same surgical CPT code 11100 with POS office (11).

**Finding and corrected billing:** The correct POS for this date of service is Outpatient Hospital (22). CPT code 11100 is adjusted to pay at the facility rate by applying the correct POS code 22.

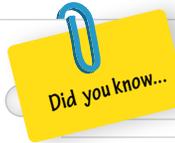
### Guidance on How Providers Can Avoid These Problems:

- ✓ Providers and suppliers should review their billing practices, paying special attention to POS coding. Ensure that your billing staffs are using the correct POS codes on professional claims to specify the entity where services were rendered. Reporting the incorrect POS code can affect reimbursement, resulting in an over- or underpayment.
- ✓ POS Codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the



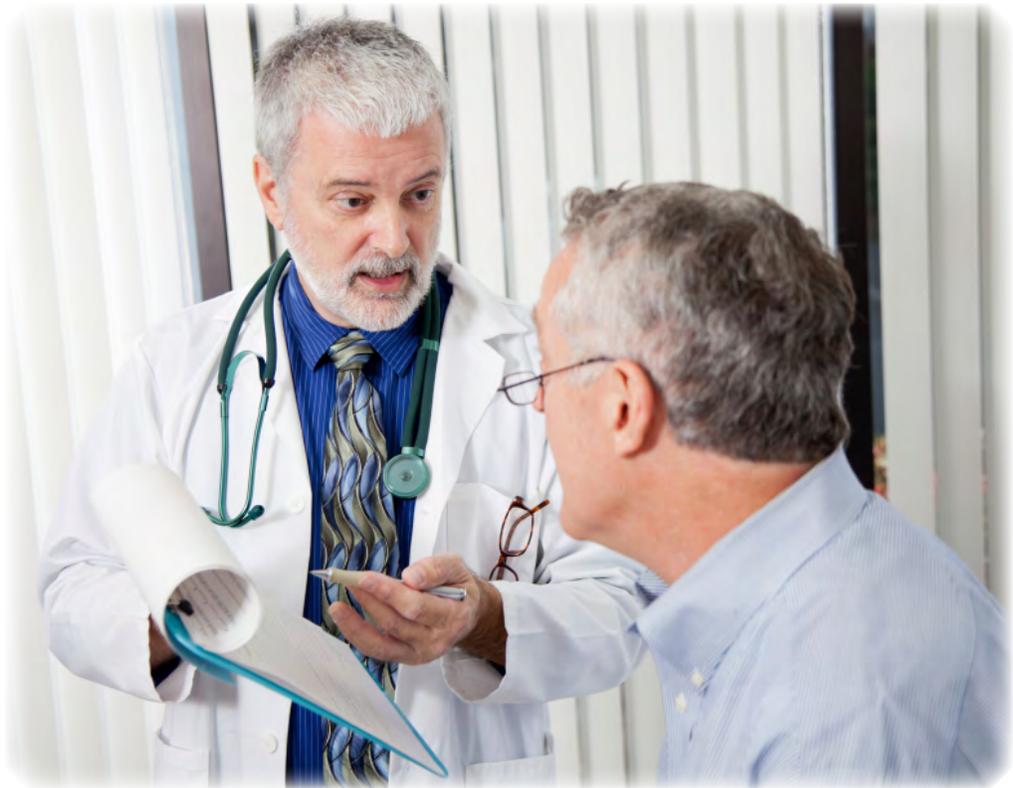
health care industry. For more information, visit <http://www.cms.gov/Medicare/Coding/place-of-service-codes/index.html> on the CMS website.

- ✓ Review the "Medicare Claims Processing Manual," Chapter 12, Section 20.4.2 - Site of Service Payment Differential, at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf> on the CMS website. This document shows the facilities where a physician's professional services are paid at the facility rate.
- ✓ Review the "Medicare Claims Processing Manual," Chapter 26, Section 10.5 - Place of Service Codes (POS) and Definitions at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf> on the CMS website. This manual section provides instructions for using the National POS Code Set with facility and non-facility designations noted for Medicare payment for services on the Physician Fee Schedule.



**Does your documentation support the medical need for the service rendered?**

- The documentation may include clinical evaluations, physician evaluations, consultations, progress notes, physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. It is maintained by the physician and/or provider. For more information, please refer to the "[Program Integrity Manual](#)", [Pub 100-08, Chapter 3, Section 3.2.3 A](#).
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## Recovery Audit Finding: Cardiac Procedures

### Provider Types Affected: Inpatient Hospitals

**Problem Description:** MS-DRG Validation requires that diagnostic and procedural information, and the beneficiary's discharge status, (as the hospital codes and reports on its claim) match both the attending physician's description and the information contained in the beneficiary's medical record. Analysis of the Centers for Medicare & Medicaid Services (CMS) Debt Collection System (DCS) identified aberrant billing patterns related to the following MS-DRGs:

- MS-DRG 228 Other Cardiothoracic Procedures with MCC;
- MS-DRG 231 Coronary Bypass with PTCA with MCC;
- MS-DRG 233 Coronary Bypass with Cardiac Catheterization with MCC;
- MS-DRG 235 Coronary Bypass without Cardiac Catheterization with MCC;
- MS-DRG 237 Major Cardiovascular Procedures with MCC or Thoracic Aortic Aneurysm Repair;
- MS-DRG 248 Percutaneous Cardiovascular Procedure with Non Drug-Eluting Stent with MCC or 4+Vessels/Stents; and
- MS-DRG 250 Percutaneous Cardiovascular Procedure without Coronary Artery Stent with MCC.

Reviewers validated these MS-DRGs to determine if the principal and secondary diagnoses, and procedures were assigned inappropriately resulting in payment errors to the hospitals.

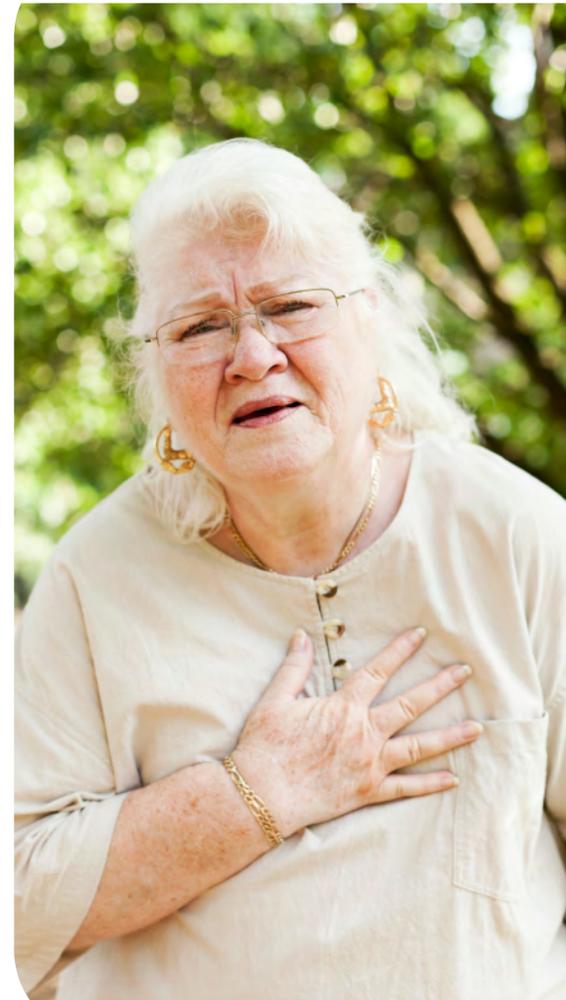
### Examples of Coding Errors:

Below are two examples of coding errors.

**Example 1:** An 80-year-old female was admitted through the Emergency Department with ICD-9-CM code 414.01 (Coronary Atherosclerosis, of Native Coronary Artery) as the principal diagnoses, and ICD-9-CM code 410.01 (Acute Myocardial Infarction, of Anterolateral Wall, Initial Episode of Care) as the secondary diagnosis. She was taken urgently to the cardiac catheterization lab for angiography which revealed: 1) A normal left main coronary artery; 2) A 99% occlusion of the proximal left anterior descending (LAD) coronary artery, and heavy calcification throughout its remainder, with a mid-course 50% lesion, and another 50% lesion distally; 3) A large circumflex coronary artery with luminal irregularities, but no high-grade obstructions; and 4) A dominant right coronary artery with a proximal 50% stenosis and a mid-course 60% stenosis.

Following angiography, she underwent successful primary angioplasty to the proximal LAD lesion, and was begun on medical therapy for the rest of her coronary disease.

**Auditor Findings:** This example demonstrates an error in sequencing the principal diagnosis. As mentioned above, the provider assigned, as the principal diagnosis, ICD-9-CM code 414.01 (Coronary Atherosclerosis, of Native Artery); and, as the secondary diagnosis, ICD-9-CM code 410.01 (Acute Myocardial Infarction, of Anterolateral Wall, Initial Episode of Care). Based on the emergency room record, history and physical, progress



notes, consultation reports, and clinical narrative; the reviewer determined that the physician's documentation did not support the principal diagnosis, as coded; and re-sequenced the acute myocardial infarction code (410.01) as the principal diagnosis.

This re-sequencing resulted in a MS-DRG change from 248 (Percutaneous Cardiovascular Procedure with Non-Drug-Eluting Stent with MCC or 4+ Vessels/Stents) to MS-DRG 249 (Percutaneous Cardiovascular Procedure with Non-Drug-Eluting Stent without MCC).

**Example 2:** A 76-year-old female admitted with an exacerbation of chronic obstructive pulmonary disease (COPD) and chest pain/angina with electrocardiographic changes, was later determined to have had an Non-ST Segment Elevation Myocardial Infarction (NSTEMI) secondary to 80-90% obstructive lesions in the proximal and mid LAD. She underwent a Percutaneous Transluminal Coronary Angioplasty (PTCA) with insertion of stents with no complications.

**Auditor Findings:** This example also demonstrates an error in sequencing the principal diagnosis. In this case, the provider assigned diagnosis code 414.01 (Coronary Atherosclerosis; of Native Coronary Artery) as the principal diagnosis. However, based on the guidance in Coding Clinic, Q2, 2001, pages 8-9, the acute myocardial infarction should have been assigned as the principal diagnosis.

The reviewer re-sequenced code 410.71 (Acute Myocardial Infarction; Subendocardial Infarction; Initial Episode of Care) as the principal diagnosis; resulting in an MS-DRG change from 248 (Percutaneous Cardiovascular Procedure with Non-Drug-Eluting Stent with MCC) to 249 (Percutaneous Cardiovascular Procedure with Non-Drug-Eluting Stent without MCC).

### Guidance on How Providers Can Avoid These Problems:

The overall finding in this review was improper sequencing of the principal diagnosis. By referencing chapter specific Coding Clinic guidelines and clarifications; in both examples, reviewers determined that inappropriate codes were selected for the principal diagnosis. (Coding Clinic, 4th Quarter 2005, page 69 for example 1; and 2nd Quarter 2001, pages 8-9 for example 2)

In order to avoid these coding errors in the future, providers should ensure that coders:

- ✓ Review and apply appropriate ICD-9-CM Official Guidelines for Coding and Reporting;
- ✓ Review Coding Clinics related to Cardiac Procedures and follow the chapter specific coding guidelines and all applicable coding clinics; and
- ✓ Review POA guidelines and ensure that indicator for all diagnoses are reported correctly

### Resources:

- ✓ The American Hospital Association Coding Clinic for ICD-9-CM is available for purchase at <http://www.ahacentraloffice.org> on the American Hospital Association website.
- ✓ The ICD-9-CM Official Coding Guidelines can be found at [http://www.ama-assn.org/resources/doc/cpt/icd9cm\\_coding\\_guidelines\\_08-09\\_sm.pdf](http://www.ama-assn.org/resources/doc/cpt/icd9cm_coding_guidelines_08-09_sm.pdf) on the Internet.
- ✓ The "ICD-9-CM Official Guidelines for Coding and Reporting," Section II – Selection of Principal Diagnosis is available at [http://www.cdc.gov/nchs/data/icd9/icd9cm\\_guidelines\\_2011.pdf](http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf) on the Internet.
- ✓ 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. This manual chapter can be found at <http://cms.gov/Regulations-and-Guidance/Manuals/downloads/pim83c06.pdf> on the CMS website.

## Recovery Audit Finding: Coronary Bypass with Percutaneous Transluminal Coronary Angioplasty (PTCA)/Cardiac Cath with MCC

**Provider Types Affected:** Inpatient Hospitals

**Problem Description:** The purpose of MS-DRG Validation is to determine that the principal diagnosis, procedures and all secondary diagnoses identified as Complications or Comorbidities (CC) and Major Complications or Comorbidities (MCC) are actually present, correctly sequenced, coded and clinically validated. When a patient is admitted to the hospital, the condition established after study found to be chiefly responsible for occasioning the admission to the hospital should be sequenced as the principal diagnosis. The other diagnosis identified should represent all (MCC/CC) present during the admission that impact the stay. The Present on Admission (POA) indicator for all diagnoses reported must be coded correctly.

Reviewers validated for principal diagnosis, secondary diagnosis, and procedure codes affecting or potentially affecting:

- MS DRG 231 (Coronary Bypass W PTCA W MCC);
- MS DRG 233 (Coronary Bypass W Cardiac Cath W MCC); and
- MS DRG 235 (Coronary Bypass W/O Cardiac Cath W MCC).

### Examples of Coding Errors:

Below are two examples of coding errors.

**Example 1:** Following a previous admission for treatment and stabilization of a myocardial infarction and pulmonary edema, a 68-year-old male was currently admitted for a

coronary artery bypass graft (CABG) secondary to diagnosed 3 vessel coronary disease (CSD). He had been discharged from the previous admission in order to have some time at home to take care of some personal business before undergoing the CABG. During the present admission, he underwent the CABG and was discharged.

**Auditor Finding:** Although not a current problem for this admission, ICD-9-CM code 518.4 (acute pulmonary edema) had been coded. The auditor deleted this code for this admission; which changed the MS DRG from 235 to 236 (Coronary Bypass W/O Cardiac Cath W/O MCC) and resulted in an overpayment.

**Example 2:** A 43-year-old male, on Highly Active Antiretroviral Therapy (HAART) for HIV, with no history of chronic obstructive pulmonary disease, asthma, or dyspnea, was admitted through the ED for chest pain. During the admission, he had a stress test that was positive with exertional angina, and was discovered to have 2 vessel coronary artery disease (CAD). During the admission, he underwent a 2 vessel coronary artery bypass graft (CABG), remaining on a ventilator for two hours. He was discharged on the fourth postoperative day.

**Auditor Findings:** While the anesthesiology progress note on the day of surgery documented respiratory failure, a subsequent progress note recorded on the first postoperative day stated "no apparent anesthesia related

complications;" and no other documentation of respiratory failure was present on other progress notes or on the discharge summary.

Therefore, the ventilator use was considered part of the normal postoperative recovery process; however ICD-9-CM code 518.5 (postoperative respiratory insufficiency), which is classified as a MCC, was coded. The auditor deleted this code, which resulted in an MS DRG change from 235 to 236 Coronary Bypass W/O Cardiac Cath W/O MCC. This change yielded an overpayment.

### Guidance on How Providers Can Avoid These Problems:

In example 1, a condition was coded that was not a problem treated or evaluated during the current admission. Coders should refer to the official coding guidelines and the Uniform Hospital Discharge Data Set (UHDDS) definitions to determine when chronic conditions should be coded.

In example 2, a normal postoperative condition was inappropriately coded. Coders should query the physician when a documented condition might be part of the normal postoperative recovery process; or if it is, rather, a codeable condition.

**Resources:**

- ✓ The “ICD-9-CM Official Guidelines for Coding and Reporting,” Section II – Selection of Principal Diagnosis, is available at [http://www.cdc.gov/nchs/data/icd9/icd9cm\\_guidelines\\_2011.pdf](http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf) on the Internet.
- ✓ The American Hospital Association’s (AHA) Coding Clinic for ICD-9-CM is available for purchase at <http://www.ahacentraloffice.org> on the AHA 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. This manual chapter is available at <http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads//pim83c06.pdf> on the CMS website.
- ✓ The MLN fact sheet titled “Present on Admission (POA) Indicator Reporting by Acute Inpatient Prospective Payment System (IPPS) Hospitals” clarifies how to apply POA indicators to diagnosis codes for certain healthcare claims. This fact sheet is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//wPOAFactSheet.pdf> on the CMS website.



**Did you know...**

- Are you billing correctly for ordered/referred services? Will you be impacted when CMS turns on the edits for these services? See MLN Matters® articles [#SE1221](#), [#SE1011](#), and the MLN fact sheets “[Medicare Enrollment Guidelines for Ordering/Referring Providers](#)” and “[The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement](#)” to learn what you need to do.

