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

Official Information Health Care Professionals Can Trust

Medicare Quarterly Provider Compliance Newsletter

Guidance to Address Billing Errors

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

Volume 3, Issue 3 - April 2013 (Revised)

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Archive of Previously-Issued Newsletters

Note: This newsletter was revised on April 30 to delete one of the examples from the issue discussed on pages 4-6. All other information remains the same.

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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ICD-9-CM Notice: The International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official Federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act standard.

Introduction

The Medicare Fee-For-Service (FFS) program contains a number of payment systems, with a network of contractors that processes more than one billion claims each year, submitted by more than one 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.

The Centers for Medicare & Medicaid Services (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 third issue in the third year of the newsletter.

This issue includes six findings identified by Recovery Auditors and two items related to CERT findings. 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** on the CMS website.

This newsletter describes the problems, the issues that may occur as a result, the steps CMS has taken to make providers aware of the problems, and guidance on what providers need to do to avoid the issues. 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** 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** on the CMS website.

Comprehensive Error Rate Testing (CERT) Special Study: Chiropractic Services

Provider Types Affected: Physicians and Chiropractors

Background: The Comprehensive Error Rate Testing (CERT) program's reviews of claims for chiropractic services have consistently yielded high improper payment rates. Because of these review findings, the Centers for Medicare & Medicaid Services (CMS) conducted a special study of claims for chiropractic services.

The study included the following services:

- Current Procedural Terminology (CPT) code 98940 (chiropractic manipulative treatment; spinal (1 – 2 regions));
- CPT code 98941 (chiropractic manipulative treatment; spinal (3 – 4 regions)); and
- CPT code 98942 (chiropractic manipulative treatment; spinal (5 regions)).

Problem Description: The majority of chiropractic services claims errors in this review were the result of insufficient documentation. Note that the Medicare Fee-for-Service 2011 Improper Payment Rate Report's finding that insufficient medical record documentation was the most common reason (72.9%) for improper chiropractic payment. See "The Supplementary Appendices for the Medicare Fee-for-Service 2011 Improper Payment Rate Report," released on November 2, 2012 at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/CERT-Reports-Items/Nov2011Appendix.html on the CMS website).

This type of error occurs when the medical records do not contain enough information for the reviewer to make a decision about medical necessity for the item or service furnished. Some common reasons for insufficient documentation errors were:

- The documentation submitted did not adequately describe the service defined by the billed CPT code, Healthcare Common Procedure Coding System (HCPCS) code, or HCPCS modifier;
- The documentation did not include the Date of Service (DOS) or the beneficiary's name;
- There was no treatment plan documented to support a plan of care; and
- The signature was illegible.

Other errors in this special study were categorized as medical necessity errors. These errors occur when the medical records contain sufficient documentation for the reviewer to determine that the services billed were not medically necessary based upon Medicare coverage policies.

A common reason for medical necessity errors was that the submitted medical records did not support the need for the service based on the Medicare National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The rest of the medical necessity errors were due to claims in which the beneficiary symptoms were not related to the spinal regions manipulated.

Example: Mr. Jones' medical record showed that he had an injury that led to a subluxation of the spine with acute back pain. However, as required by the chiropractic services LCD, the precise level(s) of the subluxation(s) was not specified by the chiropractor. This claim was scored as an improper payment due to an insufficient documentation error.

Guidance on How Providers Can Avoid These Problems:

Providers who improve their compliance with Medicare documentation requirements should enjoy a lower likelihood of continued audit-identified shortcomings. The following discussion presents coverage requirements for chiropractic services, and suggested documentation practices that can help you avoid payment errors.

Chiropractic Services Requirements: Medicare coverage of chiropractic services is limited to "treatment by means of manual manipulation of the spine to correct a subluxation provided such treatment is legal in the State where performed." A subluxation is "a motion segment in which alignment, movement integrity, and/or physiological function of the spine are altered although contact between joint surfaces remains intact." No other diagnostic or therapeutic service furnished by a chiropractor is covered. For Medicare payment purposes, a

chiropractor must place modifier "AT" on a claim when providing active/corrective treatment to treat acute or chronic subluxation.

One of the primary documentation requirements for reimbursement of chiropractic services include a subluxation demonstrated by x-ray (although the x-ray is not reimbursable unless ordered, taken and interpreted by a doctor of medicine or osteopathy) or by physical examination. In addition, there are specific documentation requirements for the initial and subsequent chiropractic patient visits[1].

The "Medicare Benefit Policy Manual," Chapter 15, Section 240, which is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf**, describes medical record documentation requirements of chiropractic services. This discussion is summarized below:

- For the initial chiropractic visit, the documentation must include the following information:
  (1) patient history;
  (2) description of present illness and evaluation of musculoskeletal/nervous system through physical examination;
  (3) diagnosis (primary diagnosis must be subluxation);
  (4) treatment plan; and
  (5) date of initial treatment.

The physical examination must demonstrate at least two of the four following criteria; (1) pain/tenderness; (2) asymmetry/misalignment; (3) abnormal range of motion; and (4) tissue/tone changes. One of these criteria must be either asymmetry/misalignment or abnormal range of motion. For each subsequent visit, the documentation requirements include: (1) patient history (lists such items as changes since last service); (2) physical examination; and (3) documentation of treatment provided at each visit.

CMS suggests that providers keep the following documentation practices in mind:

- Signature requirements - Medical record documentation must be authenticated by the author's legible signature. Please refer to the national provider signature requirements published in the "Medicare Program Integrity Manual," Chapter 3, Section 3.3.2.4, which is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf** on the CMS website.
- Documenting Procedures - Document procedures as soon as possible after performing them, and include the code on which the service is based in that documentation.
- Self Audit - A helpful technique for assuring good documentation is to periodically self-audit claims against records to determine if the records support the chosen codes. Auditing and correcting non-conforming office practices help minimize claim errors that occur with the clerical task of preparing and submitting the claim. It is also helpful for providers who use devices to assist manipulations to clearly document the device's name, and, if necessary, send with the records submitted to auditors, a device description or other information describing how the device meets CMS requirements for assistive devices.
- Medical Necessity - Thorough documentation of clinically relevant (and CMS required) documentation elements serve to create a clear picture of the patient's baseline condition, treatments provided, and a treatment timeline in terms of the patient's symptomatic functional response.

Documentation of the initial evaluation and of periodic reevaluations at reasonable intervals is essential.

a) At the initial evaluation, the patient's presenting condition (symptoms, physical signs, and function) must be described in objective, measurable terms along with pertinent subjective information; and must provide a clear description of the mechanism of injury and how it negatively impacts baseline function. A clear plan of treatment that includes treatment goals (expected duration and frequency) and the clinical milestones to be used as measures of progress is also necessary.

b) In documenting the periodic reevaluations, you should demonstrate the patients' progress in objective, rather than conclusory, terms. The evaluation elements, noted in a) above, need not be documented at each treatment; however, they must be present

[1]Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, Section 240 (Rev. 127, 05-28-10), **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf**

often enough to show measurable progress, or failure to progress. And, above all, they must be included with the documentation of any procedures sent to Medicare auditors.

c) You should document modifications in the treatment plan, when needed because of failure to satisfactorily progress in the clinically reasonable and predicted timeframe. In addition, you should adequately demonstrate that your treatments provide more than merely short term symptom control without any associated longer term functional improvement.

Resources:
Specific details regarding documentation requirements and other chiropractic services information is available in the following:

- ✓ "Medicare Benefit Policy Manual," Chapter 15, Sections 30.5 and 240 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf on the CMS website; and
- ✓ "Medicare Claims Processing Manual," Chapter 12 (Physicians/Nonphysician Practitioners, Section 220 (Chiropractic Services)) at http://www.cms.gov/Regulations-and-Guidance/Guidance/manuals/downloads/clm104c12.pdf on the CMS website.
- ✓ Medicare Chiropractic Services Booklet, available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Chiropractic_Services_Booklet_ICN906143.pdf on the CMS website; and
- ✓ The Supplementary Appendices for the Medicare Fee-for-Service 2011 Improper Payment Rate Report, released on November 2, 2012, available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/CERT-Reports-Items/Nov2011Appendix.html on the CMS website, which contains the latest data revealing the relative types and rates of chiropractic documentation errors leading to payment problems.

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.

- The Centers for Medicare & Medicaid Services has posted an updated Medicare FFS Version 5010 835 Health Care Claim Payment/Advice Companion Guide to the Medicare FFS Companion Guides web page.

Comprehensive Error Rate Testing (CERT) Finding: Split/Shared Evaluation & Management Services

Provider Types Affected: Physicians and Non Physician Practitioners (NPP)

Background: A Split/Shared service is an encounter in which a physician and an NPP, such as a Nurse Practitioner (NP), Physician Assistant (PA), Clinical Nurse Specialist (CNS), or Certified Nurse-Midwife (CNM)) each personally perform a substantive portion of an Evaluation/Management (E/M) visit face-to-face with the same patient on the same date of service.

Problem Description: The most common cause of improper payments identified for these claim types was insufficient documentation errors. Most of these errors were due to insufficient documentation to support that both the physician and NPP performed a substantive portion of the split/shared E/M service.

Example: A split/shared E&M claim was submitted for payment. While the submitted documentation contained a physician's signature on the NPP's clinical note, no other documentation was made by the physician supporting that the physician performed a substantive portion of the split/shared E&M service. This claim was scored an improper payment due to an "insufficient documentation error."

Guidance on How Providers Can Avoid These Problems:

As noted in the Medicare Fee-for-Service 2011 Improper Payments Report (found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/CERT-Reports-Items/MedicareFFS2011CERTReport.html on the CMS website), a major driver of E/M improper payments during the 2011 reporting period was insufficient documentation. "If it isn't documented, it hasn't been done" is an adage that is frequently heard in the health care setting. (Quoted from the Evaluation and Management Services Guide, which you can find at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html on the CMS website).

As mentioned above, a split/shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient in which both the physician and a qualified NPP (who must be in the same group practice or be employed by the same employer) personally perform a substantive portion of the E/M visit face-to-face with the same patient, on the same date of service. A substantive portion of an E/M visit involves all, or some portion of, the history, exam, or medical decision making (all key components of an E/M service).

The split/shared E/M visit applies only to selected E/M visits and settings (hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non-facility clinic visits, and prolonged visits associated with these E/M visit codes). The split/shared E/M policy does not apply to critical care services or procedures and a split/shared E/M visit cannot be reported in the SNF/NF setting.

(For more information regarding split/shared E/M policy issues, please refer to the "Medicare Claims Processing Manual," Chapter 12, Section 30.6.13, Subsection H, which you can find at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf on the CMS website).

The following rules for reporting split/shared E/M services between physicians and NPPs (summarized below) are described in the "Medicare Claims Processing Manual," Chapter 12, Section 30.6.1:

1. In the office/clinic setting, when the physician performs the E/M service, or when the E/M service is a split/shared encounter between the physician and NPP, is provided to an "established" patient, and meets "incident to" requirements; you must report using the physician's National Provider Identifier (NPI) and signature. ("Incident to" a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness).

If "incident to" requirements are not met for the shared/split E/M service, however, the service must be billed under the NPP's NPI and signature.

(You can find more about "incident to" requirements in the "Medicare Benefit Policy Manual," Chapter 15, Section 60.1 at http://www.cms.gov/Regulations-and-Guidance/Guidance/manuals/Downloads/bp102c15.pdf on the CMS website.)

2. When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's NPI. However, if there was no face-to-face encounter between the patient and the physician, the service may only be billed under the NPP's NPI.

For example, if the NPP sees a hospital inpatient in the morning and the physician follows with a later face-to-face visit with the patient on the same day, either the physician or the NPP may report the service.

Sufficient medical record documentation is the key to proper reimbursement for split/shared evaluation/management services.

Resources:

- ✓ The "Medicare Claims Processing Manual," Chapter 12, Section 30.6.13, Subsection H is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf on the CMS website).
- ✓ The "Medicare Benefit Policy Manual," Chapter 15, Section 60.1, is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/manuals/Downloads/bp102c15.pdf on the CMS website.
- ✓ The Evaluation and Management (E/M) Services Fact Sheet: Complying with Documentation Requirements is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Evaluation_Management_Fact_Sheet_ICN905363.pdf on the CMS website.

Did you know...

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: Neoplasm Surgery

Provider Types Affected: Inpatient Hospitals

Problem Description: The Office of Inspector General (OIG), the Recovery Audit Contractor Demonstration Project (2005-2008), and the Comprehensive Error Rate Testing (CERT) program (2007 and 2008) found errors in assignment of Joint Procedures Medicare-Severity Diagnosis Related Groups (MS-DRGs) that currently map to the following MS-DRGs:

- 826 Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Major O.R. Procedure with Major Complication or Comorbidity (MCC)
- 827 Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Major O.R. Procedure with Complication or Comorbidity (CC)
- 828 Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Major O.R. Procedure without CC/MCC
- 829 Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other O.R. Procedure with CC/MCC
- 830 Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other O.R. Procedure without CC/MCC
- 834 Acute Leukemia without Major O.R. Procedure with MCC
- 835 Acute Leukemia without Major O.R. Procedure with CC
- 836 Acute Leukemia without Major O.R. Procedure without CC/MCC

The OIG identified errors in the sample that could be traced to the hospitals' medical record and admission practices. An analysis of billing data indicates that a potential aberrant billing practice may exist for these MS-DRG assignments.

The Recovery Auditors conducted MS-DRG validation of claims, which requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded on the hospital claim, match both the attending physician description and the information contained in the medical record. Reviewers validated for MS-DRGs 826, 827, 828, 829, 830, 834, 835, and 836, for diagnoses and procedures affecting the MS-DRG assignment. Recovery Auditors found a number of improper payments in the studied claims.

Here is an example of these claims:

EXAMPLE: Patient is a 77-year-old female admitted with shortness of breath, cough and fever determined to be secondary to pneumonia. She has a history of acute myelogenous leukemia/5q-myelodysplastic syndrome (AML/5q-MDS). She is followed by her physician and is currently on third line Vidaza. She has required transfusions of packed red cells in the past.

She came into the emergency department (ED) with a 2-3 day history of shortness of breath, weakness, cough with blood-tinged sputum and fever. She had no rigors or shaking chills. She denies epistaxis or hematemesis. She did not see any blood in her stool or urine and is not having any severe pain. She also required supplemental oxygen while in the ED, initially presenting with a Pulse Oxygen in the 80's on room air. She was found to be anemic with a hemoglobin of 8.4 and platelets of 14,000. Her international normalized ratio (INR) was 1.2.

Past Medical History: Transfusion-dependent 5q-MDS, now converted to AML. Last CBC showed approximately 20% blasts. She is on third line Vidaza. She has history of atrial fibrillation while in the hospital in May, for which she takes Cardizem CD, until it was discontinued because of hypotension. She has a history of shingles involving her right face. Takes Glucophage 500 mg. PO BID.

Labs: WBCs 21,000, Hgb 8.4, Hct 27.3, Na 135, K+ 4.7, Cl 98, CO2 31, BUN 17, creatinine 0.4, LFTs WNL, Chest x-ray in the ED revealed an infiltrate in the right lower lobe of the lung, new since chest X-Ray on June 8. CXR of 6/27 shows worsening pneumonia.

Summary: The patient was admitted with right lower lobe pneumonia. She was started on antibiotics. She also has acute myelogenous leukemia and anemia. She went on to develop a left-sided pneumonia, became hypotensive, and passed away.

Finding: The provider assigned 205.00 Myeloid Leukemia, Acute, and Without Mention of Remission, as principal diagnosis. The reason for the admission was determined to be pneumonia. Review findings in this case show that pneumonia was the condition that led to the patient's admission. The patient also had acute myelogenous leukemia and anemia due to the AML. Since pneumonia was the reason for the admission, it should be reported as the principal diagnosis. The acute myelogenous leukemia and anemia should be reported as secondary diagnoses.

Coding Change: This change results in a reassignment of MS-DRG from 834 Acute Leukemia w/o Major O.R. Procedure w MCC to 194 Simple Pneumonia & Pleurisy w CC.

Discussion: Selection of Principal Diagnosis

The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." The UHDDS definitions are used by hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No, 147), pp. 31038-40.

Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc.).

In determining principal diagnosis, the coding conventions in the International Classification of Diseases, Ninth Revision (ICD-9-CM), Volumes I and II, take precedence over these official coding guidelines. (See Section I.A., Conventions for the ICD-9-CM).

The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation the application of all coding guidelines is a difficult, if not impossible, task.

Guidance on How Providers Can Avoid These Problems:

- ✓ Review applicable sections of ICD-9-CM Official Guidelines for Coding and Reporting.
- ✓ Select the Principal Diagnosis and remember that the circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the UHDDS as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
- ✓ Code and sequence complications associated with malignancies or with the therapy based on the applicable ICD-9-CM guidelines.

Resources:
ICD-9-CM Official Guidelines for Coding and Reporting, Section 1.C.2.c.1: Anemia Associated with Malignancy.

Recovery Audit Finding: Pancreas, Liver & Shunt Procedures, Medicare Severity-Diagnosis Related Groups (MS-DRG) 405, 406, and 407

Provider Types Affected: Inpatient Hospitals

Problem Description: The RAC Demonstration Project (2005 through 2008) found an overwhelming majority of errors in assignment for DRG 191 and 192, currently MS-DRG 405, 406, and 407, resulting in overpayments to hospitals. The MS-DRGs examined were:

- MS-DRG 405 Pancreas, Liver & Shunt Procedures with major complication or comorbidity (MCC)
- MS-DRG 406 Pancreas, Liver & Shunt Procedures with complication or comorbidity (CC)
- MS-DRG 407 Pancreas, Liver & Shunt Procedures without CC/MCC

The Recovery Auditors identified errors in the studied claims and medical records data that could be traced to the hospitals' medical record practices. An analysis of the billing data indicates that a potential aberrant billing practice may exist for these DRGs.

Findings: The review of claims showed a very high percentage with coding errors. 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, match both the attending physician description and the information contained in the beneficiary's medical record.

Here is an example of a problematic claim:

EXAMPLE: 46-year-old female presented with multiple endocrine neoplasia (MEN) type I syndrome with gastrinoma of the pancreas. Patient has had flushing, night sweats, diarrhea, and abdominal pain after meals.

Admitting diagnosis: Type II gastric carcinoid with pancreatic gastrinoma.

Past medical history: Diabetes insipidus, DM, Barrett's esophagus, ulcers, osteoporosis, parahypopituitarism.

Operative note: Underwent preoperative injection and returned for Neoprobe guided exploration. Post-operatively, patient developed acute bronchospasm while being extubated, therefore was re-intubated in the operating room. Patient also went into cardiopulmonary arrest due to withdrawal syndrome, and ultimately pronounced dead on post-operative day one.

Finding: According to documentation in the medical record, this patient was admitted with MEN type I (multiple endocrine neoplasia) with gastrinoma of the pancreas. The hospital assigned code 157.4 (Malignant neoplasm of the islet of Langerhans) as the principal diagnosis.

Effective October 1 2007, new codes were created for multiple endocrine neoplasia (MEN). Multiple Endocrine Neoplasia Type I is assigned to code 258.01 ((Multiple endocrine neoplasia [MEN] type 1).

As a result, the principal diagnosis is changed to 258.01 MEN type I. This causes the DRG to change from DRG 406 Pancreas, Liver, and Shunt Procedures to DRG 629 Other Endocrine, Nutritional and Metabolic O.R. Procedures with CC.

Discussion of New Codes: Based on Coding Clinic Fourth Quarter 2007, page 70.

Effective October 1, 2007, new codes have been created to uniquely report multiple endocrine neoplasia (MEN). Prior to this change, Wermers syndrome (MEN type I) was indexed to code 258.0, Polyglandular activity in multiple endocrine adenomatosis, while Sipples syndrome (MEN Type IIA) was indexed to code 193, Malignant neoplasm of thyroid gland. These codes did not adequately classify these complex syndromes.

Multiple endocrine neoplasia (MEN) syndromes are a group of rare, autosomal dominant mutations in genes regulating cell growth. They involve adenomatous hyperplasia and malignant tumor formation in several endocrine glands. MEN is also referred to as multiple endocrine adenomatosis, and familial endocrine adenomatosis.

MEN is currently classified as Type I, Type IIA and Type IIB as follows:

- Multiple Endocrine Neoplasia Type I (258.01) is also referred to as Wermers syndrome. Type I MEN is defined by hyperfunctioning tumors of all four pancreatic islets (including gastrinoma, insulinoma, glucagonoma, vasoactive intestinal peptide (VIP) tumor (VIPoma), or pancreatic polypeptide producing tumor (PPoma), parathyroid glands, and the anterior pituitary (including prolactinoma, somatotropinoma, corticotropinoma, or nonfunctioning tumors). Lipomas, angiofibromas, or tumors of the adrenal gland cortex have also been associated with MEN Type I.
- Multiple Endocrine Neoplasia Type IIA (258.02) is also referred to as Sipples syndrome. It is characterized by medullary thyroid carcinoma, pheochromocytoma, and hyperparathyroidism caused by parathyroid gland hyperplasia.
- Multiple Endocrine Neoplasia Type IIB (258.03) is defined by medullary thyroid tumor and pheochromocytoma. Associated abnormalities include mucosal neuromas, medullated corneal nerve fibers, and marfanoid habitus.
- The coding clinic directs coders to assign additional codes along with codes in category 258 to identify malignancies and other conditions associated with this syndrome. Refer to pages 99-100 of the Coding Clinic issue for information about the new V-codes that describe family history and genetic susceptibility to MEN.

Guidance on How Providers Can Avoid These Problems:

✓ In example 1, the coder may have chosen the RFA of the liver as principal lesion, when in fact, the colon adenocarcinoma was the primary tumor. Ensure that coders follow the chapter specific coding guidelines and all applicable coding clinics. Coders should also apply proper sequencing rules when applicable.

✓ In example 2, the coder may have chosen the principal diagnosis based on incorrectly reading the principal diagnosis of Type II gastric carcinoid with pancreatic gastrinoma. When the principal diagnosis is a syndrome, the primary syndrome should be chosen as the principal diagnosis.

Did you know...

In order for Medicare to cover a power mobility device (PMD), the supplier must receive the written prescription within 45 days of a face-to-face examination by the treating physician, or discharge from a hospital or nursing home, and before the PMD is delivered. The date of service on the claim must be the date the PMD device is furnished to the patient. A PMD cannot be delivered based on a verbal order. If the supplier delivers the item prior to receipt of a written prescription, the PMD will be denied as non-covered.

For more details, please refer to the Medicare Learning Network® fact sheet on this topic titled, "**Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements**."

Recovery Audit Finding: Medical Necessity Review for Medicare Severity-Diagnosis Related Group (MS-DRG) 181 Respiratory neoplasms with complication or comorbidity (CC)

Provider Types Affected: Inpatient Hospitals and Admitting Physicians

Problem Description: In March 2010, the Government Accountability Office (GAO) identified RAC demonstration vulnerabilities that had not yet received any corrective action. Many of these open issues were related to the improper payments that were not considered medically necessary. While these types of claims appear accurate on the face of the claim, the Centers for Medicare & Medicaid Services (CMS) has determined that provider education and additional review are necessary in order to decrease the number of improper payments.

As a result, CMS pre-approved certain MS-DRGs for medical necessity reviews.

Many of the claims reviewed with MS-DRG 181 were found to have improper overpayments due to medically unnecessary inpatient hospitalizations.

Medicare Policy: Medicare pays for inpatient hospital services that are medically necessary for the setting billed. The "Medicare Benefit Policy Manual," Chapter 1, Section 10, states that 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, i.e., 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 which can be made only after the physician has considered a number of factors, including 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.

Factors to be considered when making the decision to admit include such things as:

- ✓ 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.

Admissions of particular patients are not covered solely on the basis of the length of time the patient actually spends in the hospital. In certain specific situations, coverage of services on an inpatient or outpatient basis is determined by the following rule for **Minor Surgery or Other Treatment:**

> When patients with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for only a few hours (less than 24), they are considered **outpatients** for coverage purposes regardless of the hour they came to the hospital, whether they used a bed, and whether they remained in the hospital past midnight.

Here are two examples of these claims:

EXAMPLE 1: The patient is a 78-year-old male who presented to the facility for a scheduled CT guided placement of three gold fiducials adjacent to right ostophrenic lower lobe tumor and placement of two right pneumothorax catheters for iatrogenic pneumothorax. The admitting diagnosis was 197.0 Secondary Malignant Neoplasm of Respiratory System; Lung.

(***Note:*** Fiducial markers are gold seeds or stainless steel screws that are implanted in and/or around a soft tissue tumor, or within the bony spine, to act as a radiologic landmark and to define the target lesion's position with millimeter precision. They are typically placed using CT or other percutaneous image-guided method. There

may be other appropriate fiducial placement methods as well, including endoscopic or surgical approaches, as determined by the participating physician. To track lesions in 6 degrees (including translational and rotational movements), fiducials may be recommended, depending upon the exact circumstance and lesion. Fiducials must be fixed relative to other fiducials and relative to the tumor to ensure targeting accuracy.

History and Physical: Patient has a past medical history significant for melanoma that was excised in 1993 with no recurrences since then, chronic myelogenous leukemia in complete remission on Gleevec, hip replacements, cataract surgery, inguinal hernia repair, Lyme disease, hemorroidectomy, cerebral aneurysm, and hypertension, who presents for an elective CT guided gold fiducial placement. Per the patient's current thoracic surgeon, the patient underwent thyroidectomy in 1992 and has had local occurrences in the neck necessitating repeat operations, most recently in July 2004. A recent PET CT scan showed enlarging nodule, one in the right costophrenic sulcus and one in the lingual which was barely perceptible. A biopsy of the right costophrenic sulcus nodule showed malignant tumor compatible with metastatic papillary thyroid cancer. The patient is completely asymptomatic from a pulmonary point of view and the rest of the imaging suggests that there is no other disease. His respiratory status is good. He has good exercise tolerance and exercises at YMCA several times a week. He is well-looking, slightly hoarse, no adenopathy in his neck or his axilla. His chest is clear to auscultation and his abdomen is non-tender. Local therapy to his two lung nodules is appropriate. The patient's BP was 133/73, pulse 76, respirations 16, temperature 96.4, and an oxygen saturation of 99% on room air. The physician's assessment was metastatic thyroid cancer, status post local control of primary tumor with bilateral oligometastatic disease, biopsy proven, and right costophrenic sulcus tumor.

Operative Note: Patient presented for an elective CT guided placement of three gold fiducials adjacent to right costophrenic lower lobe tumor and placement of two right pneumothorax catheters for iatrogenic pneumothorax. This patient had papillary thyroid cancer, multiple surgeries with local control. He developed bilateral lung nodules. He had a history of melanoma with negative sentinel lymph node. A biopsy of the right lower lobe lesion confirmed cancer compatible with metastatic papillary thyroid cancer. It was not iodine avid and, as such, not amenable to treatment with radioactive iodine. Local therapy was recommended given the indolent nature of the cancer. The patient was marked for appropriate placement for fiducial markers. There were two at the level of the tumor, one anterior and one posterior and another one two cm. higher up. The area was prepped and then instilled with lidocaine. Three fiducial markers were inserted and then the positioning was checked, with good results. The other two were then put in and deployed. They appeared in good position, but with a moderate pneumothorax. Per physician, drainage was appropriate, the area was prepped and a small Cook catheter was inserted. CAT scan showed small residual pneumothorax with the catheter in good position and the three fiducials in good position. There was no significant pleural blood or pulmonary contusion. The procedure was performed without incident and the patient did not experience any complications. The chest was secured with a dressing and the patient was to be admitted for observation.

Discharge summary: The patient was discharged home after remaining hemodynamically stable throughout the night with no complications. The patient was instructed to return to the cancer center in 1-2 weeks for follow-up. The patient was instructed that the incision site should have the dressing left on for 48 hours, no bathing in a tub, no swimming in a pool, until tube site was well healed. No new medications were added to the patient's home medication regime.

Finding: This type of procedure is frequently associated with the expectation of a brief stay (less than 24 hours), unless complications occur or serious pathology is uncovered. The plan of care could have been implemented and completed within 24 hours. Even if the expected outcome were not reached within that time frame, the patient could have been safely admitted to inpatient status within 24 hours. Therefore, this inpatient admission did not meet the criteria for inpatient admission because the procedure was performed without incident and the patient did not experience any complications necessitating admission.

EXAMPLE 2: The patient is a 76-year-old male who presented to the hospital for an elective computed tomography guided fine needle aspiration (FNA) of the right upper lobe of the lung with placement of a pigtail catheter/ chest tube. An outpatient computed tomography scan revealed an increased consolidated infiltrate in the right upper lobe and new right lower lobe infiltrate. A positron-emission tomography (PET) scan obtained in April 2009 revealed a right upper lobe mass with suspicion for a small lesion in his liver as well as bony metastasis. The patient had moderate right pleural effusion.

Admitting diagnosis: 518.89 Other diseases of lung, Not elsewhere

On the day of admission a repeat PET scan was performed which revealed a small lesion in the liver as well as bony metastasis. There was also a moderate right pleural effusion seen. The pathological slides showed atypical cells present.

History and Physical: Emphysema-oxygen dependent, pneumonia, chronic obstructive pulmonary disease (COPD), bladder cancer, cerebrovascular accident and peripheral neuropathy. The patient's BP was 150/60, pulse 72, respirations 18 and temperature 36.0 C (96.8F).

Physical examination: awake, alert, oriented and no apparent distress. The patient was wearing his nasal cannula. Head and neck were normal. The pupils were equal and reactive to light and accommodation. The sclerae were anicteric. The cranial nerves were intact and there were no neurological focal deficits. The neck was supple with no lymphadenopathy. The heart rate and rhythm were regular. The patient had distant breath sounds and crackles bilaterally at the lung bases. The abdomen was soft and non-tender.

At the time of admission, the physician's assessment and treatment plan: Patient with a history of COPD and abnormal CT scan of the chest. His pulmonary function test reveals that his FEV1 is 53% of predicted. He is willing to have a FNA of the lung mass as well as the pigtail placement for drainage of the pleural effusion. It seems that the patient has metastatic lung cancer or metastatic bladder cancer. The physician's addendum stated, "I reviewed another pathology report of bronchial washings which showed malignant cells confirmed. Therefore, a fine-needle aspiration probably is not necessary but the patient still needs the CT-guided pigtail placement."

Operative Note: The patient was brought to the CT OR suite and placed in the left lateral decubitus position with all bony prominences padded. Due to the patient's significant cardiac and pulmonary comorbidities, no IV sedation was used. The right upper lobe lesion was localized in relation to a radiopaque marker placed along the skin, and the entry point for the needle was marked out on the patient. The patient's right chest was prepped and draped in the standard fashion. Approximately 10 ml. of 1% lidocaine was used to infiltrate the skin. A 25 gauge needle was inserted at the predetermined entry point and guided toward the mass with CT scan guidance. The central core of the needle was removed and FNA was performed. A total of three samples were obtained and a specimen given to the cytopathologist for review. The suspicious cells could not definitively rule out metastatic bladder cancer, and diagnosis was deferred until after analysis of the cell block. A post-procedure CT scan was performed, and there was no evidence of a pneumothorax or intrapulmonary hemorrhage. On review of an additional post-procedure CT scan, there was a small right pleural effusion but not large enough to justify the pigtail placement.

The patient tolerated the procedure well, and the patient was taken to recovery in stable condition.

Discharge summary: 76-year-old male with a history of emphysema who is oxygen dependent. The patient had a percutaneous, CT guided fine needle aspiration. The patient's procedure and post-operative course were uneventful throughout the hospital stay. The patient resumed oral intake the same day and was discharged home the following day with instructions to follow up with the thoracic surgeon in 2 weeks.

Finding: This type of procedure is generally performed with the anticipation of a brief hospital stay (less than 24 hours) for the following reasons:

- ✓ Endoscopic ultrasound (EUS) guided fine-needle aspiration (FNA) is a minimally invasive alternative technique for mediastinal staging of non-small cell lung cancer.
- ✓ During the past 30 years, numerous studies have shown the accuracy and safety of radiographically guided transthoracic lung biopsy procedures. The use of coaxial biopsy systems decreases the number of passes through the pleura in an effort to reduce the frequency of pneumothorax.
- ✓ Pneumothorax remains the most common complication of CT-guided lung biopsy. Review of the literature reveals variable rates of pneumothorax that range from 8% to 64%. Most institutions have moved toward use of 19-gauge needles or smaller to reduce the rate of bleeding complications.

This patient did not meet criteria for inpatient admission because the patient had an uneventful procedure and post-operative course and resumed oral intake the same day. If the patient experienced serious complications or serious pathology was determined, the patient's status could have been changed to an inpatient status at that time.

Guidance on How Providers Can Avoid These Problems:

- ✓ Hospitals and admitting physicians should be educated regarding the medical necessity of brief evaluation and treatment not requiring 24 hours of care that do not meet standard inpatient admission.
- ✓ Providers should review the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 1, Section 10, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf on the CMS website, regarding criteria for inpatient admissions.

Did you know...

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**.

Recovery Audit Finding: Esophagitis, Gastroenteritis, and Miscellaneous Digestive Disorders with MCC DRG 182 (MS-DRG 391)

Provider Types Affected: Inpatient Hospitals

Problem Description: Medicare pays for inpatient hospital services that are medically necessary, reasonable and appropriate for the setting billed. In addition, patients covered under hospital insurance are entitled to have payment made on their behalf for inpatient hospital services. See the "Medicare Benefit Policy Manual," Chapter 1, Section 10, at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf on the CMS website on the Centers for Medicare & Medicaid Services (CMS) website.

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. See http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf on the CMS website.

The medical record must indicate 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/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

The physician or other practitioner responsible for a patient's care at the hospital is responsible for deciding whether the patient should be admitted as an inpatient. Factors to be considered when making the decision to admit include such things as:

- ✓ The severity of the signs and symptoms exhibited by 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.

Recovery Auditors conducted medical necessity reviews to substantiate the need for inpatient admission versus observational level of care for patients with diagnosis (DRG 391) Esophagitis, Gastroenteritis, and Miscellaneous Digestive Disorders with MCC.

Finding: In reviewing claims for MS- DRG 391, Recovery Auditors found that the requirements for inpatient status as outlined in Medicare's regulatory documents had not been met.

EXAMPLE 1: Admitting Diagnosis - Noninfectious Gastroenteritis/Colitis NEC/NOS - Patient is a 65-year-old male with a past medical history of diabetes, hypertension, and Coronary Artery Disease who presented to the ED on June 14 at 1734 hours at the request of his surgeon with complaint of sudden abdominal pain, diarrhea, and vomiting lasting for 2 hours.

The patient's initial vital signs revealed his blood pressure was133/69, pulse rate 79, respiratory rate 19 with oxygen saturation 97%, and temperature 98.4. The triage nurse noted that the patient was feeling better, he denied nausea or diarrhea, and he was scheduled for double bypass surgery Monday. His doctor told him to get checked out. His physical exam revealed that his abdomen had mild distention, his bowel sounds were normal, and there was no tenderness.

The ED treatment included an IV bolus of 500ml normal saline, and a CT of his abdomen/pelvis was consistent with gastroenteritis. The patient stated at the time of ED discharge, "feels like my normal stomach", and he denied pain and nausea. The attending physician documented in the history and physical that the patient's abdominal exam was negative. The plan of care included a bland diet and getting an Ultrasound of the gallbladder as an outpatient.

An order for Admit was written by the ED physician on June 14 at 2048 hours. On June 15 at 1020 hours an order was received to cancel surgery (June 16), and then at 1150 hours to

change to status to Observation and discharge home.

Finding: For Example 1, a diagnosis of Gastrointestinal (Acute/Adult) 2008 was used. Under clinical finding, abdominal pain was selected.

- ✓ The patient did not have diverticulitis on imaging, mental status change, temp greater than 100.4, or vomiting, protracted, which has to be active at the time of admission despite multiple doses of oral or rectal antiemetics.
- ✓ Another subset that could be used was vomiting/diarrhea greater than or equal to two findings.

The patient did not meet any of the two subset findings. Therefore, the severity of illness criteria was not met for inpatient admission.

EXAMPLE 2: Patient is an 81-year-old female with a past medical history of diabetes, hypertension, cardiac disease, and diverticulitis. She previously had a partial colectomy due to Clostridium Difficile Colitis with a recent reversal of her ileostomy in June 2009. She presented to the ED after being seen by a Primary Care Physician at 2000 hours on November 11, 2009, with a complaint of severe abdominal pain that radiated to her back. The patient stated that "she feels like her stomach is going to explode". Her ED vital signs were: heart rate 85, blood pressure138/75, respiratory rate 18, oxygen saturation 98% on room air, and temperature 97.5. Abdominal pain was 10/10. Physical assessment in the ED was unremarkable; abdomen was soft and non-tender with positive bowel sounds x 4. ED treatment included a one-time dose of Zofran, Pepcid, Morphine, and an IV bolus of 500ml of Normal Saline. Her lab tests were within normal limits, and a CT scan was negative for acute findings. The ED nurse documented in her assessment that, at the time of transfer to the floor, the patient's pain was 0/10, lying comfortable in bed. The patient was transferred to the floor at 0830 hours.

Her admitting diagnosis was "Abdominal pain, unclear etiology, possibly acute gastroenteritis." The attending physician documented in her history and physical that she had abdominal pain with unclear etiology, possible Gastroenteritis, and she may be able to go home tomorrow. A Gastroenterology consultant stated that her pain was resolved in the ED and may represent acute gastroenteritis. Additionally, a Surgical Consult was ordered and that physician documented that pain completely resolved after she moved her bowels.

Finding: For Example 2, a diagnosis of Gastrointestinal (Acute/Adult) 2009 was used, and under clinical finding, abdominal pain was selected. A review of the medical record indicated that the patient did not have diverticulitis on imaging, mental status change, temperature greater than 100.4, or vomiting. Therefore, the severity of illness criteria was not met for inpatient admission.

Guidance on How Providers Can Avoid These Problems:

Hospitals and physicians are encouraged to review MLN Matters® SE1037 Guidance on Hospital Inpatient Admission Decisions, which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1037.pdf on the CMS website.

This article provides guidance on hospital inpatient admission decisions.

Resources:
Refer to the "Medicare Program Integrity Manual":

- ✓ Chapter 6, Section 6.5.2.A is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf on the CMS website. This section of the manual states that inpatient care is required only if the patient's medical condition, safety, or health would be significantly and directly threatened if care were provided in a less intense setting.
- ✓ Chapter 13 Section 13.1, 13.1.1, and 13.1.3 covers National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) and is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf on the CMS website.

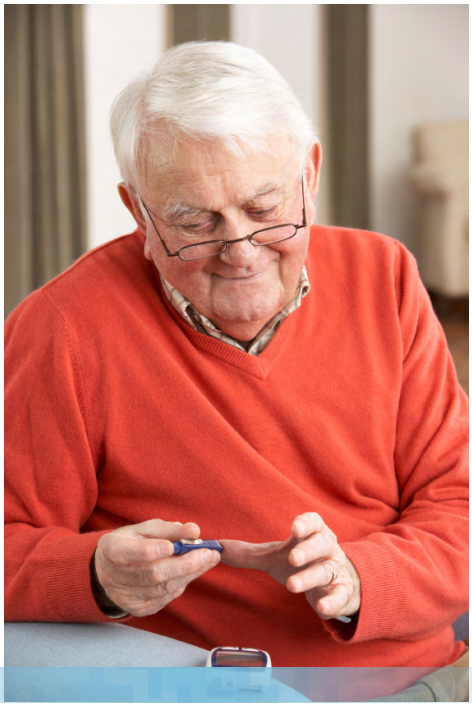
Also, see the "Medicare Benefit Policy Manual":

- ✓ Chapter 1, Section 10 covers inpatient hospital services covered under Part A and is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf on the CMS website.
- ✓ Chapter 6, Section 20.6 covers hospital services covered under Part B and is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf on the CMS website.

- ✓ Chapter 10 is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf on the CMS website. This section of the manual explains that the physician determines whether the patient needs inpatient care and gives criteria for this choice.

Additional information is in the "Medicare Claims Processing Manual" as follows:

- ✓ Chapter 3, Section 40.2.2 explains charges to beneficiaries for Part A services and is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf on the CMS website.
- ✓ Chapter 4, Sections 290.1 and 290.2.2 provide an overview of outpatient observation services and reporting hours of observation. See http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf on the CMS website.



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Looking for the latest new and revised MLN Matters® articles? The Medicare Learning Network® offers several ways to search and quickly find articles of interest to you:

- MLN Matters® Search Engine: an advanced search feature that allows you to search MLN Matters® articles from 2004 to the current year.
- MLN Matters® Index: a list of common keywords and phrases contained within MLN Matters® articles. Each index is organized by year with the ability to search by specific keywords and topics. Most indices link directly to the related article(s). For a list of available indices, visit the MLN Matters® Articles web page and scroll down to the 'Downloads' section.

Recovery Audit Finding: Acute Inpatient Hospitalization - Signs and Symptoms w/o MCC (DRG 948)

Provider Types Affected: Inpatient Hospitals

Problem Description: Medicare pays for inpatient hospital services that are medically necessary, reasonable, and appropriate for the setting billed. Medical documentation is reviewed to determine that services were medically necessary, reasonable, and appropriate for acute inpatient admission. Recovery Auditors conducted complex reviews of acute inpatient hospitalization claims with Medicare Severity Diagnosis Related Group (MS-DRG) 948, Signs and Symptoms without MCC, and the following two examples are discussed. In both examples a Medicare claim was submitted and paid for a zero-day acute inpatient admission under Signs and Symptoms w/o MCC (DRG 948).

Finding: Based on CMS regulations, First-look Analysis Tool for Hospital Outlier Monitoring (FATHOM) Reports, RAC Demonstration experience, and Recovery Auditor Region D Data Analysis, Recovery Auditors identified short-stay inpatient admissions as a source of overpayments.

EXAMPLE 1: Admission Date: 07/24/2008 Discharge Date: 07/24/2008

Patient is a 39-year-old female who presented to the ED with fatigue and headache along with continual falling asleep. She reported taking two Baclofen tablets, one Percocet, and smoking marijuana on the morning of the presentation to the ED. An ambulance was called to transport her to the ED when she fell upon rising from an afternoon nap. CT head and lab work in ER were reported as normal except for mild anemia. Examination reported give-way weakness of the lower extremities. Urine drug screen confirmed presence of opiates, tetrahydrocannabinol (THC), tricyclics, and oxycodone.

The admission plan stated, "We will watch her tonight, as she does seem to be improving significantly, and we will plan an MRI tomorrow morning." Patient improved with discharge examination describing 5/5 strength in her lower extremities with shaking and mention of "a question of whether the patient is causing the leg symptoms or not, and certainly unsure at this time if that is the case." On 7/24, the MRI order was changed to outpatient MRI, and the patient was discharged.

Finding: The Recovery Auditor determined that inpatient requirements were not met. The "Medicare Program Integrity Manual," Chapter 6, Section 6.5.2.A, states that inpatient care is required only if the patient's medical condition, safety or health would be significantly and directly threatened if care were provided in a less intense setting.

EXAMPLE 2: Admission Date: 08/08/2008 Discharge Date: 08/08/2008

Patient is a 78-year-old female who presented to the ED with increasing lethargy. On July 1, 2008, the patient was admitted to acute inpatient after she fell and suffered a pelvic fracture. She was admitted to a skilled nursing facility (SNF) on July 8th for rehabilitation where she completed a course of physical therapy over about three weeks. Approximately six days prior to this admission, she was discharged home in her usual state of good health.

At home, she continued to take OxyContin (oxycodone). She developed increasing lethargy and weakness and was evaluated in the ED. The patient was given IV Dilaudid for her pelvic pain. When first evaluated in the ED she was sleeping. She was rousable, but quickly fell back to sleep. She answered simple questions appropriately, and she had absolutely no complaints other than feeling tired. She denied headache, and she denied nausea or vomiting. She denied shaking chills, cough or shortness of breath, chest pain or pressure, and she had no abdominal pain. She has had no diarrhea, but she has been constipated.

Her past medical history included Coronary Artery Disease (CAD), hypertension (htn), diabetes mellitus type 2 (dm ii), osteoporosis, and gastroesophageal reflux disease (GERD).

The patient was noted to be a well-nourished, well-developed female, lying in bed, in no acute distress. She was lethargic, but rousable. Her pupils are constricted, but responsive bilaterally. Supple neck with full range of motion (ROM), no meningismus. Lungs, abdomen and extremities were within normal limits; Neurologic exam: lethargic but rousable, answers questions appropriately. She was alert and oriented to person,

place, and time. Her motor and sensation were normal. Her gait was not assessed. The assessment in the ED included 1. weakness/lethargy; 2. leukocytosis/bandemia; and 3. CAD/htn/hyperlipidemia. The plan included to 1. hold narcotics and consider MRI; 2. observe the patient in the hospital off of antibiotics, and 3. continue current outpatient meds.

The patient was subsequently admitted with the discharge summary stating, "When she first came into the Emergency Room apparently she did have pinpoint pupils, but for unclear reasons, was given extra Dilaudid when she complained of pain. The patient was admitted by Dr. C who felt that her lethargy may be related to narcotics. He held all further narcotics. The next day when I evaluated the patient, she was alert, oriented to time, place and person. She was able to ambulate well and was found to be stable by physical therapy evaluation. She was talking coherently. Neurological exam was completely non focal. Therefore, it is felt that she is stable for discharge."

Finding: The Recovery Auditor found that inpatient requirements were not met. The "Medicare Program Integrity Manual," Chapter 6, Section 6.5.2.A, states that inpatient care is required only if the patient's medical condition, safety or health would be significantly and directly threatened if care were provided in a less intense setting.

Guidance on How Providers Can Avoid These Problems:

Correcting improper payments through post-payment review both corrects the claim(s) identified and demonstrates accurate billing practice. Hospitals and physicians are encouraged to review MLN Matters® SE1037 Guidance on Hospital Inpatient Admission Decisions, which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1037.pdf on the CMS website and which provides guidance on hospital inpatient admission decisions.

Resources:
See the following sections of the "Medicare Benefit Policy Manual":

- ✓ Chapter 1, Section 10 discusses inpatient hospital admission requirements, and it is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf on the CMS website.
- ✓ Chapter 6, Section10 discusses Medical and Other Health Services furnished to Inpatients of Participating Hospitals. See http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf on the CMS website.

Also see the "Medicare Program Integrity Manual" as follows:

- ✓ Chapter 6, Section 6.5.2 is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf on the CMS website. This section of the manual states that inpatient care is required only if the patient's medical condition, safety, or health would be significantly and directly threatened if care were provided in a less intense setting.
- ✓ Chapter 13, Section 13.1 includes Medicare Policy, National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf on the CMS website.

Recovery Audit Finding: MS-DRG Validation: Female Reproduction Disorders

Provider Types Affected: Inpatient hospitals

Problem Description: The Office of Inspector General (OIG), Recovery Audit Contractor (RAC) Demonstration Project (2005-2008) and Comprehensive Error Rate Testing (CERT) (2207 and 2008) found errors in assignment of Female Reproduction Disorders MS-DRGs that currently map to MS-DRGs 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, and 750, resulting in overpayments or underpayments to hospitals.

The OIG identified that errors in the sample could be traced to the hospitals' medical record and admission practices. An analysis of billing data indicates that a potential aberrant billing practice may exist for these MS-DRG assignments.

Recovery Auditor MS-DRG validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded on the hospital claim, match both the attending physician description and the information contained in the medical record. Auditors validated for the following MS-DRGs, for diagnoses and procedures affecting the MS-DRG assignment:

- 734 - Pelvic evisceration, radical hysterectomy and radical vulvectomy with complication or comorbidity (CC)/major complication or comorbidity (MCC);
- 735 - Pelvic evisceration, radical hysterectomy and radical vulvectomy without CC/MCC;
- 736 - Uterine and Adnexa Procedures for Ovarian or Adnexal Malignancy with MCC;
- 737 - Uterine and Adnexa Procedures for Ovarian or Adnexal Malignancy with CC;
- 738 - Uterine and Adnexa Procedures for Ovarian or Adnexal Malignancy without CC/MCC;
- 739 - Uterine and Adnexa Procedures for Nonovarian/ Adnexal Malignancy with MCC;
- 740 - Uterine and Adnexa Procedures for Nonovarian/ Adnexal Malignancy with CC;
- 741 - Uterine and Adnexa Procedures for Nonovarian/ Adnexal Malignancy without CC/MCC;
- 742 - Uterine and Adnexa Procedures for Nonmalignancy with CC/MCC;
- 743 - Uterine and Adnexa Procedures for Nonmalignancy without CC/MCC;
- 744 - D&C, Conization, Laparoscopy and Tubal Interruption with CC/MCC;
- 745 - D&C, Conization, Laparoscopy and Tubal Interruption without CC/MCC;
- 746 - Vagina, Cervix and Vulva Procedures with CC/MCC;
- 747 - Vagina, Cervix and Vulva Procedures without CC/MCC;
- 748 - Female Reconstructive Procedures;
- 749 - Other Female Reproductive System O.R. Procedures with CC/MCC; and
- 750 - Other Female Reproductive System O.R. Procedures without CC/MCC.

Here are two examples of these claims:

EXAMPLE 1: The patient is a 75-year-old female who comes to the hospital for a planned vaginal hysterectomy.

Admitting diagnosis: 618.1 Uterine prolapse without mention of vaginal wall prolapse.

- The patient has a history of using a pessary for a prolapsed uterus that has excoriated the vagina making a vaginal hysterectomy necessary.
- The patient has a history of a CVA and has been cleared for the hysterectomy and perineoplasty.
- It was agreed that the procedure would be performed under spinal or epidural anesthesia. Her physical examination was unremarkable including finding a uterus that is small with no palpable masses.

The operative procedure went as planned. Estimated blood loss was minimal. The patient was awakened and was taken to the recovery room in stable condition.

Postoperatively, a cardiologist was consulted and found the patient to be in atrial fibrillation that lasted several days. The patient also experienced some chest pain after the procedure that included a change in her EKG. At the time of the transfer to a monitored

bed, the cardiology consult was completed. The patient was intolerant of some of her medications, with symptoms of nausea. Physical and occupational therapists worked with the patient as she normally uses a walker at home. She was discharged home with instructions to follow up in two weeks with her GYN physician.

Finding: The provider assigned 438.20 (Hemiplegia Affecting Unspecified Side) as a secondary diagnosis. Although a physician documents a history of partial paralysis, there is no documentation of hemiparesis/hemiplegia in the medical record.

Coding changes: Provider should remove code V85.41 (Body Mass Index 40.0 - 44.9, Adult) and change code 280.0 (Iron Deficiency Anemias; Secondary To Blood Loss (Chronic)) to code 285.9 (Anemia, Unspecified).

These changes result in reassignment of MS-DRG 742 (Uterine and Adnexa Procedures for Non-Malignancy with CC/MCC) to MS-DRG 743 (Uterine and Adnexa Procedures for Non-Malignancy without CC/MCC).

EXAMPLE 2: 69-year-old female with a history of atrial fibrillation, who presented to the emergency room with vaginal bleeding.

Admitting diagnosis: 623.8 Vaginal Bleeding.

- The patient had been experiencing bleeding on and off times 3 weeks with an increase on the day of admission. Upon presentation the patient's hemoglobin was 10.4 and her hematocrit was 31.4. The patient denied chest pain, shortness of breath and did not experience any symptoms of nausea, vomiting or diarrhea.
- Her past medical history included atrial fibrillation, diabetes mellitus, hypercholesterolemia, hypertension and CVA. The patient has no known drug allergies. Physical examination was unremarkable and a complete blood count revealed slightly decreased lab values. The patient was admitted to telemetry for monitoring of her condition.
- Operative procedure consisted of surgical removal of fibroid. Estimated blood loss during the procedure noted to be 250-300ml. Hemoglobin and hematocrit were further decreased postoperatively to 8.1 and 23.4 respectively. The patient was admitted to telemetry for monitoring of her condition. The patient remained stable; no packed red blood cells were transfused. The patient did not experience any further vaginal bleeding and was discharged home.

Finding: Patient admitted for vaginal bleeding with an admitting diagnosis of 623.8 Vaginal Bleeding. The provider assigned codes V85.4 (Body Mass Index (BMI) 40 And Over, Adult) and 280.0 (Iron Deficiency Anemias; Secondary To Blood Loss (Chronic)) as secondary codes for this admission.

- In order to code BMI from other clinician notes, the provider must provide documentation of a clinical condition, such as obesity, to justify reporting a code for the body mass index. There is no documentation from the provider regarding obesity.
- The anemia that is documented is identified as postoperative anemia; however, it is not specified as anemia due to blood loss. This condition cannot be assumed based on other diagnoses in the record.

Code changes: Provider should remove code V85.41 (Body Mass Index 40.0 - 44.9, Adult) and change code 280.0 (Iron Deficiency Anemias; Secondary To Blood Loss (Chronic)) to code 285.9 (Anemia, Unspecified).

These changes result in reassignment of MS-DRG 742 (Uterine and Adnexa Procedures for Non-Malignancy with CC/MCC) to MS-DRG 743 (Uterine and Adnexa Procedures for Non-Malignancy without CC/MCC).

Guidance on How Providers Can Avoid These Problems:

- Review ICD-9-CM Official Guidelines for Coding and Reporting, Section III Reporting Additional Diagnoses.

Other Diagnoses are defined as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded." Coding Clinic 4th Quarter 2007, page 224.

- Review Coding Clinics for the issue at hand.

The provider must provide documentation of a clinical condition, such as obesity, to justify reporting a code for the body mass index. Coding Clinic 4th Quarter 2008, page 191.

When postoperative anemia is documented without specification of acute blood loss, code 285.9, Anemia, unspecified, is the default Coding Clinic 1st Quarter 2007, page 19.

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