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**Archive of Previously-Issued Newsletters**

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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 are called Medicare Administrative Contractors (MACs) and they process claims, make payments to health care professionals 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 first issue in the fourth year of the newsletter.

This issue includes five 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](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 that 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): Clinic End-Stage Renal Disease (ESRD) Services

Provider Types Affected: ESRD Facilities

Background: The Comprehensive Error Rate Testing (CERT) program’s reviews of claims for Clinic ESRD services have consistently yielded high improper payment rates. Claims for Clinic ESRD services selected by CERT included Part A non-DRG claims with the two digit type of bill (TOB) 72 (Renal Dialysis Facility (RDF)).

“End Stage Renal Disease is a kidney impairment that is irreversible and permanent and requires either a regular course of dialysis or kidney transplantation to maintain life. Dialysis is the process of cleaning the blood and removing excess fluid artificially with special equipment when the kidneys have failed.” (Federal Register (FR) Vol. 73, No. 73, Tuesday April 15, 2008).

Problem Description: Clinic ESRD services had an improper payment rate of 4.9 percent during the November 2011 Report Period with a projected improper payment amount of $398 million. The improper payment rate was 5.3 percent during the November 2012 Report Period with a projected improper payment amount of $523 million. Most of the improper payments for Clinic ESRD claims are due to insufficient documentation. The specific element of the medical record most often incomplete or not authenticated is the patient plan of care. Often, the patient plan of care references a protocol (or algorithm) for treatment or laboratory investigations that is missing or outdated.

Example: A beneficiary received a month of dialysis services at a Clinic ESRD, and the claim was sampled by CERT. Medical records submitted for review included progress note reports, a form labeled Medication Orders, dialysis flow sheets, a form labeled Ordered Labs Report, a Medication Summary Report, and a Biochemical Lab Report for the month of service dated March 19, 2012—April 30, 2012. The medical records provided in response to a request for additional documentation, included duplicates of documentation previously submitted. No response was received after an additional call requesting more documentation to support the claim.

CERT Finding: Specifically, the documentation submitted did not contain valid physician’s orders for dialysis and medications. Therefore, the claim was scored an improper payment due to insufficient documentation to meet Medicare documentation requirements.

Guidance on How Providers Can Avoid These Problems:

✓ According to Title 42 of the Code of Federal Regulations (CFR), Section 413.210(a), to qualify for payment, ESRD facilities must meet the conditions for coverage in part 494. Per 42 CFR 494.80(d), the ESRD patient’s comprehensive reassessment and revision of the plan of care must be conducted at least annually for stable patients and at least monthly for unstable patients. Per 42 CFR 494.80(a), the patient’s comprehensive assessment must include, in addition to other elements, an evaluation of factors associated with anemia, such as hematocrit, hemoglobin, iron stores, and potential treatment plans for anemia, including administration of erythropoiesis-stimulating agent(s). 42 CFR 494.90(b) states that the patient’s plan of care must be signed by team members, including the patient or the patient’s designee.

✓ Implementation of the initial plan of care must begin within the latter of 30 calendar days after admission to the dialysis facility or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session. Implementation of monthly or annual updates of the plan of care must be performed within 15 days of the completion of the patient reassessments specified in 42 CFR 494.80(d).

✓ The dialysis facility must ensure that all dialysis patients are seen by a physician, nurse practitioner, clinical nurse specialist, or physician’s
assistant providing ESRD care at least monthly, as evidenced by a monthly progress note placed in the medical record, and periodically while the hemodialysis patient is receiving in-facility dialysis.

**Resources:**

Providers who would like more information on avoiding improper payments for ESRD facility claims can visit or refer to:

- **42 CFR 413.210(a)** (Qualifications for payment)
- **42 CFR 494.80(d)** (Condition: Patient Assessment)
- **42 CFR 494.30(b)** (Condition: Patient Plan of Care)
Comprehensive Error Rate Testing (CERT): Immunosuppressive Drugs

Background: Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) and Comprehensive Error Rate Testing (CERT) program reviews of claims for immunosuppressive drugs have consistently yielded high improper payment rates. During the November 2011 Report Period, the improper payment rate for immunosuppressive drugs was 55.4% with a projected improper payment amount of $218 million. The improper payment rate for immunosuppressive drugs was 50.4 percent during the November 2012 Report Period with a projected improper payment amount of $193 million. The following discussion presents coverage requirements for claims for immunosuppressive drugs, examples of improper payments for immunosuppressive drugs, the common causes of improper payments for immunosuppressive drugs, and resources for providers.

Requirements for Claims for Immunosuppressive Drugs:

The Social Security Act, Section 1861(s)(2)(J) (which you can find at [http://www.ssa.gov/OP_Home/ssact/title18/1861.htm](http://www.ssa.gov/OP_Home/ssact/title18/1861.htm)) and 42 Code of Federal Regulations (CFR) 410.30 (which you can find at [http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=001a9bcb014e0bb865c31cbed37da1af&rgn=d iv8&view=text&node=42:2.0.1.2.10.2.35.19&d idno=42](http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=001a9bcb014e0bb865c31cbed37da1af&rgn=d iv8&view=text&node=42:2.0.1.2.10.2.35.19&d idno=42)) provide for the coverage of prescription drugs for immunosuppressive therapy furnished to an individual who receives an organ transplant for which Medicare payment is made.

Further, Medicare statute and benefit category language narrowly define, and closely regulate, the coverage of immunosuppressive drugs; and stipulate that immunosuppressive drugs are eligible for reimbursement only when all of the following criteria are met:

I. Immunosuppressive drugs are prescribed following either:

A. Kidney (V42.0), heart (V42.1), liver (V42.7), bone marrow (V42.81)/stem cell (V42.82), lung (V42.6), or heart/lung (V42.1 and V42.6) transplant; or,

B. Whole organ pancreas (V42.83) transplant performed concurrent with or subsequent to a kidney transplant (V42.0) because of diabetic nephropathy (performed on or after July 1, 1999); or,

C. Intestinal transplant (V42.84) (performed on or after April 1, 2001); or,

D. Pancreatic islet cell transplant (V42.89) or partial pancreatic tissue transplantation (V42.89) performed on or after October 1, 2004 that is conducted as part of a National Institutes of Health (NIH)-sponsored clinical trial; or,

E. Pancreas transplants alone (performed on or after April 26, 2006) that meet the following criteria:

1. The transplant is performed in a facility that is Medicare-approved for kidney transplantation; and

2. Beneficiary must have a diagnosis of type I diabetes and:

   a. Must be beta cell autoantibody positive; or,

   b. Must demonstrate insulinopenia, (fasting C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory’s measurement method). A fasting glucose must be obtained when performing a fasting C-peptide determination. Fasting C-peptide levels are considered valid when a concurrently obtained fasting glucose is <225 mg/dL; and,

3. Must have a history of labile (brittle or medically-uncontrollable) insulin-dependent diabetes mellitus resulting in documented recurrent, severe, acutely life-threatening metabolic complications requiring hospitalization(s). Complications may include frequent hypoglycemia where the beneficiary is unaware, recurring severe ketoacidosis, or recurring severe hypoglycemic attacks; and,

4. Must have been under the care of an endocrinologist and have clinical
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II. The transplant met Medicare coverage criteria in effect at the time (e.g., approved facility for kidney, heart, intestinal, liver, lung, or heart/lung transplant; national and/or local medical necessity criteria; etc.); and,

III. The beneficiary was enrolled in Medicare Part A at the time of the transplant; and,

IV. The beneficiary is enrolled in Medicare Part B at the time that the drugs are dispensed; and,

V. The drugs are furnished on or after the date of discharge from the hospital following a covered organ transplant.

If criteria I-V are not met, the drug(s) will be denied as noncovered.

If criteria I, II, and III are met, the transplant is considered a "covered transplant" for purposes of this policy whether payment for the transplant was made by Medicare or by another insurer.

CERT Finding: The claim was scored an improper payment due to insufficient documentation to meet Medicare documentation requirements.

Example 2: A pharmacy provided the immunosuppressive drug cyclosporine (J7502), for a beneficiary in July of 2009. Medicare paid the pharmacy for the medications and paid a dispensing fee. The medical records received for review did not include a valid signed and dated order for the medications, or documentation to support that the beneficiary had undergone a kidney transplant. Nor was there any documentation to support the treating physician’s continued medical management for a kidney transplant.

In response to a request for additional documentation, a transcript of a verbal order for cyclosporine was received. However, it was not signed by the physician or authenticated by the transcriber.

CERT Finding: The claim was scored an improper payment due to insufficient documentation to meet Medicare documentation requirements.

Guidance on How Providers Can Avoid These Problems:

✓ Most of the improper payments for claims reviewed by CERT for immunosuppressive drugs were due to insufficient documentation. Some of the most common errors that reviewers identified are listed below:
Detailed Written Order-Related Errors:

a) Copy of detailed written order was not provided;
b) Detailed written order was illegible;
c) The order was missing required elements such as:
   • Beneficiary’s name;
   • Name of drug;
   • Dosage;
   • Quantity to be dispensed;
   • Route of administration;
   • Frequency of administration;
   • Physician’s name;
   • Refill instructions;
   • Physician signature and date; or
   • The start date of the order, if different than the signature date;
d) Physician did not personally date his/her signature;
e) Items were delivered prior to obtaining a detailed written order; and
f) No written documentation of a dispensing order was provided.

d) The name of the transplant center was not provided;
e) Records are missing a signature or it is illegible; and/or
f) Records provided did not document a transplant.

Medical Record-Related Errors:

a) Copy of pertinent medical records was not provided;
b) Medical records did not document that the drug was included in the physician’s plan of care for the beneficiary;
c) Records failed to document continued use and/or medical need for the drug;

d) The name of the transplant center was not provided;
e) Records are missing a signature or it is illegible; and/or
f) Records provided did not document a transplant.

Resources:

• For questions regarding documentation requirements for immunosuppressive drug claims, you can refer to the relevant LCDs and related Policy Articles from your DME MAC. To do so, visit the following:
  – Noridian Administrative Services;
  – National Government Services;
  – CGS Administrators, LLC; and
  – NHIC Corp on the CMS website.

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Did you know...

Question:

What is the correct principal diagnosis for a patient who suffers an acute myocardial infarction (AMI) due to underlying coronary artery disease (CAD), in which an interventional procedure is carried out? The consultants are advising coders to sequence the AMI as a secondary diagnosis and the CAD as the principal diagnosis for these cases.

Answer:

No, the consultant’s advice is not correct. Sequence the AMI as the principal diagnosis since it is the acute condition and the reason for the admission. You should continue to follow correct coding and reporting practices and report the AMI as the principal diagnosis. This advice is similar to that published in Coding Clinic, Third Quarter 2009, pages 9-10.
Recovery Audit Finding: Inappropriate Payment for Vertebral Augmentation Procedure (VAPs)

Provider Types Affected: Outpatient Hospital

Problem Description: Local Coverage Determination (LCD) policy has indicated specific conditions or diagnoses that are covered for Vertebral Augmentation Procedures (VAPs). Recovery Auditors identified outpatient claims where the first-listed and/or other diagnosis codes do not match to the covered diagnosis codes in the LCD policies.

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

Example 1: On March 22, 2011, a provider submitted a claim with Healthcare Common Procedure Coding System (HCPCS) 22521 and diagnosis code 724.2.

Finding: This code is not listed on the Payer’s LCD as an ICD-9 code that support medical necessity.

Example 2: On June 8, 2011, a provider submitted a claim with HCPCS 22524 and diagnosis codes 806.4, 401.9, 782.1, 300.00, V13.02, and 429.3.

Finding: The listed diagnosis codes are not on the Payer’s LCD as ICD-9 codes that supports medical necessity.

Guidance: How Providers Can Avoid These Problems:

- Documentation supporting the medical necessity such as ICD-9 codes must be submitted with each claim. Claims submitted without such evidence will be denied as being not medically necessary. The medical record must include documentation of the specific signs, symptoms, and condition associated with the billed ICD-9 code. To establish medical necessity the medical record must indicate that other non-invasive corrective medical treatment has been tried and failed. Providers and their billing staff must use LCDs and National Coverage Determinations (NCDs), when they exist, to ensure the medical product, procedure, or service will be covered.

Conservative management includes, but is not limited to, immobilization, analgesia, physical therapy, etc.

a. Exceptions to conservative management may include a high level of pain, disability and neurologic compromise.

2. Painful non-unions of Vertebral Compression Fractures (VCF);

3. Back pain associated with osteolytic metastatic disease involving a vertebral body;

4. Back pain associated with multiple myeloma involving a vertebral body; or

5. Painful hemangiommas.

Limitations:

1. Coverage for only one procedure per lifetime per vertebra will be allowed. If a repeat procedure on a single vertebra is to be performed, medical record documentation must support the medical necessity of the repeat procedure.

2. Medicare will not provide coverage for procedures performed for asymptomatic VCFs, VCFs responding appropriately to conservative therapy, or for healed VCFs.

3. Bone biopsy is considered integral to the procedures and not separately billable.
4. Treatment of kyphosis in the absence of a painful VCF is not covered.

5. VAPs is contraindicated in osteomyelitis / discitis involving the vertebral column.

Resources:

- To ensure proper payments of VAPS, the LCDs and NCDs should be reviewed, in order to have the covered ICD codes.
- Review the LCD: Vertebroplasty (Percutaneous) and Vertebral Augmentation including cavity creation.
- Review the LCD Surgery on VAPs.

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.
Provider Types Affected: Physicians

Problem Description: After a review of Medicare policy and an analysis of data, the Recovery Auditors found a high percentage of errors on Evaluation and Management services (E/M). When E/M services are provided to patients admitted to an inpatient hospital setting, then Current Procedural Terminology (CPT) Codes 99221-99223, 99231-99233, and 99238-99239 are to be used. CPT codes 99201-99215 are to be used for E/M services provided in the physician's office, or in an outpatient or other ambulatory facility.

Most of the improper payments for E/M services are due to incorrect coding and insufficient documentation errors. Incorrect coding errors for E&M services are commonly found when the provider submitted medical documentation that supported a different E/M code than the code billed. These errors correspond to errors reported in the 2011 Comprehensive Error Rate Testing (CERT) report.

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

Example 1: An 80-year-old female was admitted to a hospital for inpatient level of care on October 17, 2012, and was discharged on October 20, 2012. A physician billed CPT Code 99205 (Office or other outpatient visit for the evaluation and management of a new patient) for date of service October 18, 2012. Date of service October 18, 2012, is during the inpatient hospital stay and data analysis confirms that the patient was not on a leave-of-absence from the hospital on that date.

Finding: CPT Code 99205 is the overpaid claim.

Example 2: A 79-year-old female was admitted to a hospital for inpatient level of care on October 23, 2012, and was discharged on October 26, 2012. A physician billed CPT Code 99205 (Office or other outpatient visit for the evaluation and management of a new patient) for date of service October 24, 2012. Date of service October 24, 2012, is during the inpatient hospital stay and data analysis confirms that the patient was not on a leave-of-absence from the hospital on that date.

Finding: CPT Code 99205 is the overpaid claim.

Guidance: How Providers Can Avoid These Problems

✓ For initial hospital care code, a physician must meet three key components for the service: (1) comprehensive history, (2) comprehensive exam, and (3) high complexity medical decision-making.

Resources:

Additional information can be found in the following manuals/publications:


• Review MLN Matters® article MM7405, Clarification of Evaluation and Management (E/M) Payment Policy outlines codes to be used for billing for inpatient visits at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7405.pdf on the CMS website.

Recovery Audit Finding: Evaluation and Management Services with Allergy Services

Provider Types Affected: Physicians

Problem Description: Evaluation and management (E/M) codes reported with allergy testing or allergy immunotherapy are appropriate only if a significant, separately identifiable service is performed. Obtaining informed consent is included in the immunotherapy service and should not be reported with an E/M code. If E/M services are reported, modifier 25 should be utilized. The Recovery Auditors concluded that the services were provided and medically necessary, but the provider billed and the Medicare paid for all or part of them more than once.

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

Example 1: On August 23, 2012, a professional bill was submitted with E/M code 99214 and Immunotherapy injections code 95117.

Finding: The billing of these two codes without modifier 25 to indicate that a significant, separately identifiable service was performed resulted in an overpayment.

Example 2: On October 25, 2012, a professional bill was submitted with E/M code 99213 and Immunotherapy one injection code 95115.

Finding: The billing of these two codes without modifier 25 to indicate that a significant, separately identifiable service was performed resulted in an overpayment.

Guidance: How Providers Can Avoid These Problems:

According to the CMS’ “Medicare Claims Processing Manual” (Chapter 12, Section 200, subsection C), in order for a physician to receive payment for a visit service provided on the same day that the physician also provides a service in the allergen immunotherapy series (i.e., any service in the series from 95115 through 95199), the physician is to bill a modifier 25 with the visit code, indicating that the patient’s condition required a significant, separately identifiable visit service above and beyond the allergen immunotherapy service provided. Medical necessity remains the key as typically allergy injections are pre-scheduled and no other services beyond the injection are scheduled. The injection code includes the minimal amount of work needed to make the determination that the patient is fit to undergo the procedure. However if the patient has a significant, separately identifiable problem that meets the requirements of an E/M service, this may be billed using Modifier 25 for claims processing.

Providers may want to focus on E/M services tied to typically scheduled services and pull the documentation and compare the “visit intent” against the content of the notes. By monitoring the occurrences of E/M services billed in conjunction with scheduled services, billing errors are less likely.

Resources:


Recovery Audit Finding: Source of Admission Code for Inpatient Psychiatric Facilities (IPFs)

Provider Types Affected: Outpatient Hospital

Problem Description: The Recovery Auditors conducted claim reviews of the Medicare Prospective Payment System (PPS) for Inpatient Psychiatric Facilities (IPFs) and determined that the majority of the time when patients are transferred within the same facility overpayments occur because the Source of Admission Code ‘D’ is not billed for those claims. Source of Admission Code ‘D’ is designated for usage when a patient is discharged from an acute hospital to their own psychiatric distinct part unit (DPU). This code will prevent the additional payment for the beneficiary’s first day of coverage at the DPU.

Under the Medicare PPS for IPFs, CMS makes an additional payment to an IPF or a DPU for the first day of a beneficiary’s stay to account for emergency department costs if the IPF has a qualifying emergency department. However, CMS does not make this payment if the beneficiary was discharged from the acute care section of a hospital to its own hospital based IPF. In that case, the costs of emergency department services are covered by the Medicare payment that the acute hospital received for the beneficiary’s inpatient acute stay.

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

Example 1: On January 10, 2010, an 85-year-old female is admitted through the Emergency Room for a one day stay in an acute inpatient hospital setting. On January 11, 2010, the patient is admitted to the inpatient psychiatric unit of the same facility. The claim for this admission was submitted with Source of Admission Code “1” (Physician Referral).

Resolution: Because the January 11th admission was a transfer from the same facility, the Source of Admission Code should be coded “D”. The incorrect Source of Admission Code resulted in an overpayment.

Example 2: On January 19, 2012, a 63-year-old male is admitted through the Emergency Room for a two day stay in an acute inpatient hospital setting. On January 21, 2012, the patient is admitted to the inpatient psychiatric unit of the same facility. The claim for this admission was submitted with Source of Admission Code “2” (Clinic Referral).

Resolution: Because the January 21st admission was a transfer from the same facility, the Source of Admission Code should be coded “D”. The incorrect Source of Admission Code resulted in an overpayment.

Guidance: How Providers Can Avoid These Problems

✓ Alert billing staffs to use Source of Admission Code “D” when transferring a beneficiary from acute care to the psychiatric unit of their facility.

Resources:
Recovery Audit Finding: Metastasis As Secondary Diagnosis
MS-DRGs 820-825, 840-842

Provider Types Affected: Inpatient Hospitals

Problem Description: Medicare Severity- Diagnosis-Related Group (MS-DRG) Validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record.

The Office of Inspector General (OIG) reported in report OAI-12-88-01010 that in reviewing claims and medical records for Medicare Severity - Diagnosis-Related Groups (MS-DRGs), errors were found in the assignment of DRG's resulting in overpayment to hospitals. The OIG identified that errors in the sample could be traced to the hospital's medical record and admission practices, and an analysis of billing data indicated that a potential aberrant billing practice may exist. Hospitals were incorrectly reporting the principal diagnosis for cases admitted with conditions such as dehydration or anemia, but who also had a documented neoplasm.

Recovery Auditors validated the following MS-DRGs for principal and secondary diagnoses and procedures as affecting or potentially affecting MS-DRG assignment:

- MS-DRG 820 Lymphoma and Leukemia with Major O.R. Procedure with MCC
- MS-DRG 821 Lymphoma and Leukemia with Major O.R. Procedure with CC
- MS-DRG 822 Lymphoma and Leukemia with Major O.R. Procedure without CC/MCC
- MS-DRG 823 Lymphoma and Nonacute Leukemia with Other O.R. Procedure with MCC
- MS-DRG 824 Lymphoma and Nonacute Leukemia with Other O.R. Procedure with CC
- MS-DRG 825 Lymphoma and Nonacute Leukemia with Other O.R. Procedure without CC/MCC
- MS-DRG 840 Lymphoma and Nonacute Leukemia with MCC
- MS-DRG 841 Lymphoma and Nonacute Leukemia with CC
- MS-DRG 842 Lymphoma and Nonacute Leukemia without CC/MCC

Example 1: A 77-year-old male with chronic lymphocytic leukemia who had been undergoing chemotherapy was seen because he had been having diarrhea for 3 weeks. It was felt that the diarrhea might be secondary to chemotherapeutically-induced gastroenteritis or infectious gastroenteritis. The patient was admitted to the hospital service with marked dehydration secondary to chronic diarrhea. He was felt to be malnourished, and he was found to be pancytopenic. He was seen in consultation by hematologist, and blood counts were monitored. He required 2 units of packed red blood cells for anemia. He was also seen in consultation by gastroenterologist. Stool studies were negative, and leukocytes were negative. The patient did not require an endoscopy. He had a normal TSH. Prior to admission he had a negative stool for Clostridium Difficile and negative stool cultures. He had no fever, and he had no severe abdominal pain. His main complaint was intractable diarrhea. He was experiencing nausea, and he did vomit in the hospital. He was placed on Zofran and Imodium around the clock and this seemed to make a big difference. The patient’s Imodium was decreased and his Zofran was stopped. Upon discharge, he was encouraged to avoid eating raw fruits and vegetables and to refrain from consuming lactose containing foods.

Finding: This patient was admitted with dehydration secondary chronic diarrhea due to chemotherapy, and the provider assigned 204.10 (Chronic Lymphoid Leukemia, Without Mention of Having Achieved Remission) as the principal diagnosis. However, this code was not validated as the principal diagnosis. The documentation in the medical record did not support the assignment of 204.10 (Chronic Lymphoid Leukemia, Without Mention of Having Achieved Remission) as the principal diagnosis. The attending physician...
stated in the discharge summary, “Patient was admitted with marked dehydration secondary to chronic diarrhea.” Per coding guidelines and documentation in the medical record, the main reason for admission was dehydration. Coding Clinic Second Quarter states, “When the admission/encounter is for the management of dehydration due to the malignancy or therapy, or a combination of both, and only the dehydration is being treated (intravenous rehydration), the dehydration is sequenced first, followed by the code(s) for the malignancy.”

Therefore, code 204.10 (Chronic Lymphoid Leukemia, Without Mention Of Having Achieved Remission) was resequenced as a secondary diagnosis and code 276.51 (Dehydration) was sequenced as the principal diagnosis. This change resulted in a reassignment of the MS-DRG from 840 (Lymphoma & Non-Acute Leukemia with MCC) to MS-DRG 640 (Miscellaneous Disorders of Nutrition, Metabolism and Fluids and Electrolytes with MCC).

Example 2: An 88-year-old female with hypertension and chronic lymphocytic leukemia had chemotherapy on 11/08, 12/08, and 01/09. She was followed by her hematologist/oncologist and seen for Procrit for her anemia. She was found to have very low hemoglobin (Hgb) and sent to the Emergency Department (ED) for blood transfusions. The patient was admitted for anemia and thrombocytopenia due to questionable ischemic changes. She was also admitted for monitoring on Telemetry. Cardiac enzymes x 3 requested. The patient was given one unit of platelets and 2 units of packed red blood cells in the ED. Hematology/oncology was called for consultation. For GI prophylaxis, she received Prilosec and for DVT prophylaxis the patient was encouraged to get out of bed to chair with assistance. The patient's primary care physician was informed of the patient's admission and plans for workup. After 2 units of red blood cells, the patient's Hgb remained stable at approximately 9. Hematology/oncology recommended getting the platelets to 10,000 so she received an additional unit of packed red blood cells and another unit of platelets bringing her platelets up to 22,000 and her Hgb up to 9.4. Hematology/oncology again recommended one additional unit of packed red blood cells and another unit of platelets. The patient was discharged to home after receiving the unit of hemoglobin and platelets and was instructed to follow-up with hematology/oncology and her primary care physician.

Finding: This patient was admitted for aplastic anemia due to Chronic Lymphoid Leukemia, and the provider assigned code 204.10 (Chronic Lymphoid Leukemia, Without Mention Of Having Achieved Remission) as the principal diagnosis. The documentation in the medical record identified the reason for admission as due to the aplastic anemia for which the patient received blood products.

Therefore, code 204.10 (Chronic Lymphoid Leukemia, Without Mention Of Having Achieved Remission) was resequenced as a secondary diagnosis, and code 284.89 (Other Specified Aplastic Anemias) was assigned as the principal diagnosis. This change resulted in a reassignment of the MS-DRG 840 (Lymphoma & Non-Acute Leukemia with MCC) to MS-DRG 809 (Major Hematologic Immune Diagnosis Except Sickle Cell Crisis & Coagulation with CC).

Guidance on How Providers Can Avoid These Problems:

✓ Review the documentation within the medical record and assign codes appropriately based on documentation.

✓ 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."


✓ Coding Clinic, Second Quarter 2005, page 9 cites ICD-9-CM Official Guidelines for Coding and Reporting: Chapter 1.C.2.c.3 Neoplasms General Guidelines-Management of dehydration due to malignancy as follows:

“When the admission/encounter is for the management of dehydration due to the malignancy or therapy,
or a combination of both, and only
the dehydration is being treated
(intravenous rehydration), the
dehydration is sequenced first,
followed by the code(s) for the
malignancy.”

✓ Coding Clinic September-
October 1984, (8) states:

“Admissions for care and treatment
of toxic effects of the drug during
the course of chemotherapy should
identify the toxic effects as the
principal diagnosis with an E code
(such as E933.1) to identify the
drug. The malignancy should be
coded as additional diagnosis.”

References:

• The “Medicare Program
Integrity Manual” (Chapter 6,
Section 6.5.3) states: “The
purpose of DRG validation
is to ensure 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’s
description and the information
contained in the beneficiary’s
medical record.” See http://
www.cms.gov/Regulations-
and-Guidance/Guidance/
Manuals/Downloads/
pim83c06.pdf on the
CMS website).

• The Uniform Hospital
Discharge Data Set (UHDDS)
Reporting of Inpatient Data
Elements, July 31, 1985,
Federal Register (Volume 50
No. 147, Pages 31038-31040).
This document contains
the UHDDS data elements
and their definitions that are
used by hospitals to report
inpatient data elements in a
standardized manner. Since
July 31, 1985, 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.). Note that 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 Office
of Inspector General (OIG)
Report OAI-12-88-01010,
“National DRG Validation Study
Special Report on Coding
Accuracy,” can be found
at http://oig.hhs.gov/oei/
reports/oai-12-88-01010.pdf
on the Internet.

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.”