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 4 Issue 4 - July 2014

ICN 909012/ July 2014

Table of Contents

Comprehensive Error Rate Testing (CERT): Bariatric Surgery 1

Comprehensive Error Rate Testing (CERT): Kyphoplasty and Vertebroplasty 3

Comprehensive Error Rate Testing (CERT): Obesity Counseling.... 5

Recovery Auditor Finding: Incorrect Billing of a Bi-Level Positive Airway Pressure Device 7

Recovery Auditor Finding: Heart Failure and Shock 8

Recovery Auditor Finding: MS-DRG 857 Postoperative or Posttraumatic Infections with Operating Room Procedure with Complications and Comorbidities (CC) 10

Recovery Auditor Finding: MS-DRG Validation: Amputations MS-DRGs 239, 240, 241, 474, 475, and 476..... 12

Archive of Previously-Issued Newsletters

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

This educational tool was prepared as a service to the public and is not intended to grant rights or impose obligations. This educational tool may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

The Medicare Learning Network® (MLN), a registered trademark of CMS, is the brand name for official CMS educational products and information for Medicare Fee-For-Service Providers. For additional information, visit the MLN's web page at http://go.cms.gov/MLNGenInfo on the CMS website.

Your feedback is important to us and we use your suggestions to help us improve our educational products, services and activities and to develop products, services and activities that better meet your educational needs. To evaluate Medicare Learning Network® (MLN) products, services and activities you have participated in, received, or downloaded, please go to http://go.cms.gov/MLNProducts and click on the link called 'MLN Opinion Page' in the left-hand menu and follow the instructions. Please send your suggestions related to MLN product topics or formats to MLN@cms.hhs.gov.

CPT only copyright 2013 American Medical Association. All rights reserved.

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 (SNFs), 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 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 fourth issue in the fourth year of the newsletter.

This issue includes four findings identified by Recovery Auditors and three 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 of those problems, 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** 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): Bariatric Surgery

Provider Types Affected: Hospitals, physicians, and other providers billing for bariatric surgery

Background: Bariatric surgery procedures are performed to treat comorbid conditions associated with morbid obesity. Two types of surgical procedures are employed. Malabsorptive procedures divert food from the stomach to a lower part of the digestive tract where the normal mixing of digestive fluids and absorption of nutrients cannot occur. Restrictive procedures restrict the size of the stomach and decrease intake. Surgery can combine both types of procedures.

CERT Study of Codes for Bariatric Surgery Procedures: The CERT reviewer conducted a special study of Healthcare Common Procedure Coding System (HCPCS) codes for bariatric surgery procedures as listed below:

- 43644 Surgical laparoscopy with gastric bypass and Roux-en-Y gastroenterostomy
- 43770 Surgical laparoscopy with placement of adjustable gastric restrictive device component

The following are descriptions of the studied bariatric surgery procedures:

- Roux-en-Y Gastric Bypass (RYGBP): The RYGBP achieves weight loss by gastric restriction and malabsorption. Reduction of the stomach to a small gastric pouch (30 cc) results in feelings of satiety following even small meals. This small pouch is connected to a segment of the jejunum, bypassing the duodenum and very proximal small intestine, thereby reducing absorption. RYGBP procedures can be open or laparoscopic.
- Adjustable Gastric Banding (AGB): The AGB achieves weight loss by gastric restriction only. A band creating a gastric pouch with a capacity of approximately 15 to 30 ccs encircles the uppermost portion of the stomach. The band is an inflatable doughnut-shaped balloon, the diameter of which can be adjusted in the clinic by adding or removing saline via a port that is positioned beneath the skin. The bands are adjustable, allowing the size of the gastric outlet to be modified as needed, depending on the rate of a patient's weight loss. AGB procedures are laparoscopic only.

Nationally Covered Indications: Laparoscopic Roux-en-Y Gastric Bypass (RYGBP) and Laparoscopic Adjustable Gastric Banding (LAGB) are covered for Medicare beneficiaries who have a Body-Mass Index (BMI) ≥ 35, have at least one co-morbidity related to obesity, and have been previously unsuccessful with medical treatment for obesity.

Insufficient Documentation Causes Most Improper Payments: Insufficient documentation caused approximately 98 percent of the improper payments. Insufficient documentation means that something was missing from the medical records. For example, there was:

- No physician's signature on the procedure note;
- No signature log or attestation submitted;
- Missing documentation on BMI greater than 35;
- Missing documentation of at least one comorbidity;
- Missing documentation of prior failure for medical treatment of obesity; and/or
- Documentation that did not meet the requirements of the National Coverage Determination, Local Coverage Determinations, and/or Articles.

Examples of Improper Payments for Bariatric Surgery

Example 1: Insufficient Documentation for Laparoscopic Gastric Bypass/Roux-en-Y
A physician billed for a laparoscopic gastric bypass/roux-en-Y. The medical records received included an unauthenticated copy of the operative report for the billed date of service. The CERT reviewer requested additional documentation from the billing provider and received physician's notes spanning eleven months of care, with a note showing failed medical management for a morbidly obese patient with worsening

health conditions. The physician's notes show a BMI of 50.4 on the day of surgery and a BMI of 44 three months post-operatively. No attestation was received for the unsigned operative report. This claim was scored as an insufficient documentation error and the Medicare Administrative Contractor (MAC) recouped the payment from the provider.

Example 2: Insufficient Documentation for Adjustable Gastric Banding
A physician billed for an adjustable gastric banding. The CERT reviewer received an operative note and pathology report. However, the treating physician's clinical documentation of beneficiary's BMI, co-morbid conditions related to obesity and documentation of previously unsuccessful medical treatment for obesity were missing. Submitted documentation was insufficient to support service billed per Medicare requirements. Additional documentation was requested but none was received. This claim was scored as an insufficient documentation error and the MAC recouped the payment from the provider.

Resources: You can find more information on how to avoid errors on claims for bariatric surgery in the following:

- The "Medicare National Coverage Determination (NCD) Manual," Chapter 1, Part 2, Section 100.1, NCD for Bariatric Surgery for Treatment of Morbid Obesity, which is available at http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=57&ncdver=5&NCAId=258&NcaName=Bariatric+Surgery+for+the+Treatment+of+Morbid+Obesity&IsPopup=y&bc=AAAAAAAACAAAAA%3D%3D& on the Centers for Medicare & Medicaid Services (CMS) website.
- The Local Coverage Determinations and Local Coverage Articles, which are available at http://www.cms.gov/medicare-coverage-database/ on the CMS website.

Did you know...

REVISED product from the Medicare Learning Network® (MLN)

"Intensive Behavioral Therapy (IBT) for Obesity," Booklet, ICN 907800, Downloadable

Comprehensive Error Rate Testing (CERT): Kyphoplasty and Vertebroplasty

Provider Types Affected: Hospitals, physicians, and other providers billing for Kyphoplasty and Vertebroplasty

Background: Kyphoplasty (vertebral augmentation) and vertebroplasty are minimally invasive spinal surgery procedures used to treat vertebral compression fractures or diseased vertebral bodies.

- Kyphoplasty (vertebral augmentation) includes the creation of a cavity and attempts to restore vertebral body height and alignment. The collapsed vertebral body is drilled and a device that displaces, removes, or compacts the compressed area of the vertebrae is used to create a cavity prior to injection of bone cement.
- Vertebroplasty is a therapeutic procedure that consists of the injection of a biomaterial (aka bone cement) under imaging guidance (either fluoroscopy or Computed Tomography (CT)) into a cervical, thoracic, or lumbar vertebral body stabilizing the fractured vertebral body which facilitates restoring mobility and decreasing disability and pain.

CERT Study of Codes: The CERT reviewer conducted a special study of Healthcare Common Procedure Coding System (HCPCS) codes for kyphoplasty or vertebroplasty procedures, thoracic or lumbar, 22520; 22521; 22523; and 22524.

Insufficient Documentation Causes Most Improper Payments
Insufficient documentation caused approximately 97 percent of the improper payments. Insufficient documentation means that something was missing from the medical records. For example, there was:

- No physician's signature on the procedure note;
- No documentation of the patient's clinical condition;
- No documentation of the response to conservative care; and
- No documentation that met the requirements of the Local Coverage Determination.

Avoid Errors by Attending to Documentation Requirements
Local Coverage Determinations (LCDs) for kyphoplasty and vertebroplasty define the circumstances demonstrating medical necessity and the Medicare program requires that documentation is available to Medicare upon request. The documentation must include relevant medical history, pertinent physical examination, diagnosis (if known), and results of pertinent diagnostic tests and/or procedures.

Examples of Improper Payments for Kyphoplasty or Vertebroplasty

Example 1: Insufficient Documentation for Kyphoplasty
A physician billed for a thoracic percutaneous kyphoplasty (for the primary procedure and one additional thoracic vertebral body). The medical records received did not include detailed clinical documentation or office notes describing the beneficiary's symptoms, functional level, severity of pain, or previous treatments as required by the LCD. The submitted documentation included an operative report, the physician's orders, a cursory history, and physical exam performed on the date of the procedure, a CT report dated less than two weeks prior to the procedure, and x-ray films.

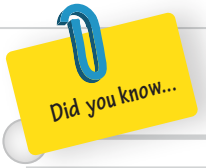
The CERT reviewer requested additional documentation from the billing provider and received duplicate documentation, an MRI report dated four days prior to the procedure, and a signed and dated surgical log. The submitted documentation did not support the documentation requirements in the governing LCD. This claim was scored as an insufficient documentation error and the MAC recouped the payment from the provider.

Example 2: Insufficient Documentation for Vertebroplasty
A physician billed for a thoracic percutaneous vertebroplasty (for the primary procedure and one additional thoracic vertebral body). An office note dated three weeks prior to the procedure stated, "The course has been gradually improving (especially last two weeks)" and "her pain has improved a great deal in the last two weeks." A procedure note was received but there was no further documentation to support the reason for surgery.

Additional documentation was requested. In response to the additional request for documentation, an office note and an x-ray report were received. These documents were dated more than three months prior to the procedure, and there was no documentation supporting the reason for the procedure. The x-ray report was of the lumbar spine (although the procedure was on the thoracic spine) and documented that "there is no compression deformity seen". This claim was scored as an insufficient documentation error and the MAC recouped the payment from the provider.

Example 3: Insufficient Documentation for Kyphoplasty
A physician billed for a percutaneous thoracic kyphoplasty (for the primary procedure and one additional thoracic vertebral body). The only documentation submitted was an unsigned operative report. In response to an additional request for documentation, a duplicate of the unsigned operative report was received, but nothing further. The submitted documentation did not support the documentation requirements in the governing LCD. This claim was scored as an insufficient documentation error and the MAC recouped the payment from the provider.

Resources: You can find more information on how to avoid errors on claims for kyphoplasty and vertebroplasty by reviewing the Local Coverage Determinations and Local Coverage Articles, available at **http://www.cms.gov/medicare-coverage-database/search/document-id-search-results.aspx?Date=12/09/2013&DocID=L32685** on the CMS website.



REVISED products from the Medicare Learning Network® (MLN)

"**Medicare Enrollment and Claim Submission Guidelines**," Fact Sheet, ICN 906764, Downloadable

Comprehensive Error Rate Testing (CERT): Obesity Counseling

Provider Types Affected: Primary care physicians and other primary care practitioners providing obesity counseling to Medicare patients

Background: Effective for claims with dates of service on or after November 29, 2011, Medicare beneficiaries with obesity (BMI ≥ 30 kg/m2) are eligible for:

- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2-6; and
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg. (6.6 lbs.) weight loss requirement during the first 6 months as discussed below.

Beneficiaries must be competent and alert at the time that counseling is provided, and the counseling must be furnished by a qualified primary care physician or other primary care practitioner in a primary care setting.

- At the 6-month visit, a reassessment of obesity and a determination of the amount of weight loss should be performed.
- To be eligible for additional face-to-face visits occurring once a month for months 7-12, beneficiaries must have achieved a reduction in weight of at least 3kg. (6.6 lbs.), over the course of the first 6 months of intensive therapy. This determination must be documented in the physician office records for applicable beneficiaries consistent with usual practice.

Medicare covers intensive behavioral therapy for obesity per National Coverage Determination 210.12 (see resource below).

CERT Study of Obesity Counseling Codes: The CERT reviewer conducted a special study of Healthcare Common Procedure Coding System (HCPCS) G0447 - Face-to-face behavioral counseling for obesity, 15 minutes.

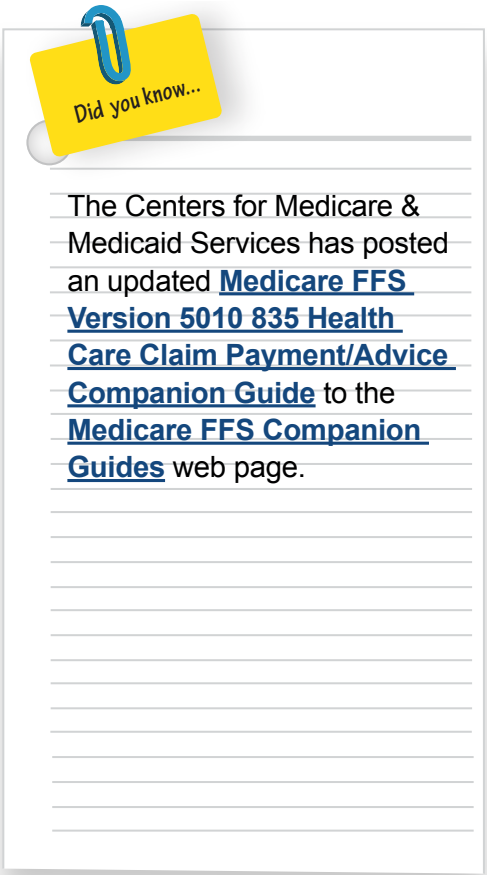
Insufficient Documentation Causes Most Improper Payments: Insufficient documentation caused approximately 92 percent of the improper payments. Insufficient documentation means that something was missing from the medical records. For example, there was:

- No physician's signature on the procedure note;
- No documentation of the patient's clinical condition;
- No documentation that the beneficiary has a BMI greater than or equal to 30kg/m2;
- No documentation that after 6 months the beneficiary lost 6.6 pounds or 3kg; and/or
- No documentation that obesity counseling and dietary assessment occurred.

Examples of Improper Payments for Obesity Counseling:

Example 1: Insufficient Documentation for Obesity Counseling
A physician billed for HCPCS G0447, face-to-face behavioral counseling for obesity, 15 minutes. The documentation reviewed was missing the following:

- Documentation of dietary (nutritional) assessment; and
- Documentation of intensive behavioral counseling and behavioral therapy to promote



sustained weight loss through high intensity interventions on diet and exercise, consistent with the 5-A framework that has been highlighted by the U.S. Preventive Services Task Force (USPSTF).

The CERT reviewer received a copy of the office visit note for the date of service, which showed follow-up of beneficiary's hypertension, type II diabetes, and chronic obstructive pulmonary disease. The assessment/plan section of the note contained only "V85.30 BMI 30.0-30.9 - Obesity Counseling & MNT provided." There was a record template that was partially illegible noting the beneficiary's weight, height, and BMI.

The CERT reviewer requested additional documentation from the billing provider and received duplicate documentation. The submitted documentation did not support the documentation requirements in the NCD. This claim was scored as an insufficient documentation error and the MAC recouped the payment from the provider.

Example 2: Insufficient Documentation for Obesity Counseling

A physician billed for a HCPCS G0447, face-to-face behavioral counseling for obesity, 15 minutes. The documentation reviewed was missing the following:

- Documentation of dietary (nutritional) assessment; and
- Documentation of intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise, consistent with the 5-A framework that has been highlighted by the USPSTF.

An office note documented a BMI of 50.5 and the practitioner's documentation of "needs to lose weight; interested in seeing nutritionist." Documentation is not sufficient to meet Medicare guidelines. Additional documentation was requested, but none was received. This claim was scored as an insufficient documentation error and the MAC recouped the payment from the provider.

Resources: You can find more information on how to avoid errors on claims for obesity counseling in the MLN Matters® article at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7641.pdf on the CMS website.

You can find more information on how to avoid errors on claims for preventive services at:

- "Quick Reference Information: Preventive Services," available at http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf on the CMS website.
- "Prevention – General Information," available at http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/ on the CMS website.
- National Coverage Determination (NCD) for Intensive Behavioral Therapy for Obesity 210.12 (Effective 11/29/2011), available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf on the CMS website.
- "Medicare Claims Processing Manual," Pub. 100-4, Chapter 18, Section 200 - Intensive Behavioral Therapy for Obesity (Effective November 29, 2011), available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf on the CMS website.

Recovery Audit Findings: Incorrect billing of a Bi-level Positive Airway Pressure Device

Provider Types Affected: Durable Medical Equipment (DME) Suppliers

Problem Description: A bi-level positive airway pressure device with back-up rate is not reasonable and necessary if the primary diagnosis is Obstructive Sleep Apnea (OSA). If billed with a diagnosis of OSA, it will be denied as not reasonable and necessary.

The Recovery Auditors conducted an automated review for claims with HCPCS: E0471-Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device and ICD-9 Diagnosis: 327.23-Obstructive sleep apnea (adult)(pediatric). A significant number of claims were found to have medical items or services claimed that were not medically necessary.

Here are two examples of errors in billing:

Example 1: Bi-level airway pressure device (E0471) was billed with diagnosis code 327.23 (Obstructive Sleep Apnea)
When bi-level airway pressure device E0471 is billed with a primary diagnosis of OSA, the service is deemed not reasonable and necessary. This billing error resulted in an overpayment and the MAC recovered the payment from the supplier.

Example 2: Bi-level airway pressure device (E0471) was billed with diagnosis code 327.23 (Obstructive Sleep Apnea).
When bi-level airway pressure device E0471 is billed with a primary diagnosis of OSA, the service is deemed not reasonable and necessary. This claim was deemed to be an overpayment, which the MAC recovered from the supplier.

Finding: According to LCD L11518, submitting bills for bi-level airway pressure device (E0471) and diagnosis of Obstructive Sleep Apnea (327.23) is incorrect.

Guidance on how providers can avoid these billing errors:

- ✓ DME Suppliers should ensure that the correct equipment is dispensed for the diagnosis listed.
- ✓ DME Suppliers should follow LCD L11518 in order for proper payment to occur.

Resources: Information is available to assist in avoiding these errors, including:

- Local Coverage Determination L11518, which is available at http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=11518&ContrId=140&ver=65&ContrVer=2&CoverageSelection=Local&ArticleType=All&PolicyType=Final&s=All&KeyWord=sleep+apnea&KeyWordLookUp=Title&KeyWordSearchType=And&NCDId=226&ncdver=3&bc=gAAAABAAAAAAAA%3d%3d& on the CMS website; and
- The "Medicare National Coverage Determinations Manual," Section 240.4 Continuous Positive Airway Pressure for Obstructive Sleep Apnea, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf on the CMS website.

Recovery Audit Findings: Heart Failure and Shock

Provider Types Affected: Inpatient Hospitals

Problem Description: Heart failure is one of the CMS' top volume Diagnostic Related Groups (DRGs). Therefore, MS-DRGs 291, 292, and/or 293 were selected to determine if the principal and secondary diagnoses were assigned inappropriately resulting in overpayments to the hospitals. An analysis of billing data indicates that a potential aberrant billing practice may exist for these Medicare Severity - Diagnosis Related Groups (MS-DRGs).

The most common errors for these MS-DRGs were related to sequencing of the principal diagnosis and improper coding of secondary diagnoses. Secondary diagnoses errors were related to selecting the improper code based on physician documentation or the addition of a secondary diagnosis that was not documented within the medical record.

Here are two examples of errors in billing:

Example 1: Incorrect diagnosis coding
An eighty-four year old female was admitted with a one day history of weakness, difficulty breathing, and tiredness. She has a past medical history for severe arteriosclerotic heart disease, peripheral artery disease, percutaneous intervention, severe osteoarthritis, hypertension, hypercholesterolemia and glaucoma. She was admitted through the emergency department with difficulty in breathing. Chest x-ray showed cardiomegaly and mild pulmonary congestion, probably some pleural effusion. Assessment at the time of admission was difficulty breathing due to flash pulmonary edema secondary to dietary indiscretion, Congestive Heart Failure (CHF) decompensated. Plan is to rule out myocardial infarction with cardiac enzymes and diuresis.

Finding: The provider added the code 511.8 - Pleural Effusion, Not Elsewhere Classifiable (NEC), not tuberculosis related. However, the code 511.9 - Pleural Effusion, Not Otherwise Specified (NOS) should have been coded, per the ICD-9-CM alphabetic index, effusion, pleural, NOS, codes to 511.9. In this case the physician did not document the pleural effusion as caused by another condition. Per coding clinic, third quarter, 1991, pleural effusion is commonly seen with CHF with or without pulmonary edema and may be reported as an additional diagnosis but not required.

The secondary diagnosis is changed from MS-DRG 291 - Heart Failure and Shock with (Major Complication or Comorbidity (MCC) to 292 - Heart Failure and Shock with Comorbid Conditions (CC) and results in an overpayment.

Example 2: Incorrect diagnosis coding
A seventy-eight year old male was admitted through the emergency department with respiratory distress and cough. After a thorough work-up in the emergency department, it was noted that the patient had some t-wave inversions in lead 1, elevated troponin at 0.13, and Brain Natriuretic Peptide (BNP) of 982. Admitting diagnosis was respiratory insufficiency, hypoxia, pneumonia, possible CHF, and elevated troponin. Patient was admitted to the cardiac telemetry bed with admission diagnoses of chest pain, dyspnea with mildly raised troponin, possible non-ST elevated myocardial infarction, CHF, leukocytosis, and community-acquired pneumonia, and a plan for a complete extensive work-up. Diagnoses at discharge were chest pain with dyspnea with mildly raised troponin, non-St elevated myocardial infarction, CHF, leukocytosis, community-acquired pneumonia, mild exacerbation of chronic obstructive lung disease, possible bronchopneumonia, uncontrolled hyperglycemia, and renal insufficiency.

Finding: The reason for admission and condition established after study was found to be the acute myocardial infarction. Therefore, the principal diagnosis was changed from 428.20 - Systolic Heart Failure, NOS to 410.71 - Subendocardial Infarction,

Initial. This change resulted in an overpayment and an MS-DRG change from 291 - Heart Failure and Shock with MCC to 280 - Acute Myocardial Infarction, Discharged Alive with MCC.

Guidance on how providers can avoid these billing errors:

- ✓ Coders should follow the ICD-9-CM alphabetic index when assigning a condition based on physician documentation and follow all coding clinic advice related to the condition being coded.
- ✓ Coders should follow the ICD-9-CM Official Coding Guidelines for selecting and sequencing the principal diagnosis.

Resources:

- The "Medicare Program Integrity Manual," Chapter 6, Section 6.5.3, DRG Validation Review, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf on the CMS website.
- Review the ICD-9-CM Coding Manual applicable for the dates of service; and
- Review the ICD-9-CM addendums available at http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html on the CMS website.

Did you know...

Looking for the latest new and revised MLN Matters® articles? Subscribe to the MLN Matters® electronic mailing list! For more information about MLN Matters® and how to register for this service, go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/What_Is_MLNMatters.pdf and start receiving updates immediately!

Recovery Audit Findings: MS-DRG 857 Postoperative or Posttraumatic Infections with Operating Room (OR) Procedure with Complications and Comorbidities (CC)

Provider Types Affected: Inpatient Hospitals

Problem Description: Recovery Auditors validated MS-DRG 857, for principal diagnosis, secondary diagnosis, and procedures, affecting or potentially affecting, the MS-DRG assignment. (At this time, medical necessity was excluded from review). 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, match both the attending physician description and the information contained in the beneficiary's medical record. The Recovery Auditors found improper diagnosis code assignment which affected DRG reimbursement resulting in improper payment.

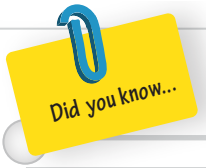
Here are two examples of errors in billing:

Example 1: Improper diagnosis code assignment
Patient is an 83-year-old white male with a history of right degenerative joint disease, who underwent a right total knee replacement recently and is now admitted with an infected knee hematoma. His past medical history includes asthma, coronary artery disease, atrial fibrillation, hypertension, congestive heart failure, myocardial infarction, ischemic cardiomyopathy, and hyperlipidemia. Patient underwent arthrotomy with drainage of the hematoma.

Finding: According to the documentation provided in the medical record, the infection was due to an internal prosthetic device, total knee prosthesis. Therefore, the principal diagnosis code 998.59, other operative infection, was removed and replaced with diagnosis code 996.66, Infection and inflammatory reaction due to internal prosthetic device implant and graft. Also, the hematoma noted was also due to a complication of the prosthetic device. The secondary diagnosis code of 998.12, hemorrhage or hematoma complicating a procedure, was replaced with ICD-9 diagnosis code 996.77 other complication due to internal joint prosthesis.

The DRG was changed from DRG 857 to DRG 487, Knee Procedures with Principal Diagnosis of Infection without CC/MCC, and the overpayment is noted.

Example 2: Improper diagnosis code assignment
Patient is an 85-year-old male who was admitted for evaluation and therapy of a presumed pacemaker pocket infection. Patient has a past medical history including sick sinus syndrome, paroxysmal atrial fibrillation, coronary artery disease, mitral regurgitation, aortic stenosis, hyperlipidemia, carotid artery stenosis, and left ventricular hypertrophy. The patient underwent a surgical procedure to treat pocket infection of a pacemaker resulting in successful explantation of a dual-chamber pacemaker with pocket infection.



The Medicare Learning Network® (MLN) Product Ordering System was recently upgraded to add new enhancements. You can now view an image of the product and access its downloadable version, if available, before placing your order. To access a new or revised product available for order in hard copy format, go to **MLN Products** and click on "MLN Product Ordering Page" under "Related Links" at the bottom of the web page.

Finding: Other postoperative infection (998.59) was coded as principal diagnosis; however, according to documentation provided, code 996.61, Infection and inflammatory reaction due to cardiac device, implant, and graft (996.61) should have been assigned as principal diagnosis. Code 998.59 should be removed from the claim because the code excludes infections due to implanted devices.

The DRG was changed from DRG 857 to DRG 261, Cardiac Pacemaker Revision except

Device Replacement with CC. The overpayment was noted.

Guidance on how providers can avoid these billing errors:

- ✓ Coders should adhere to the ICD-9 CM Coding and Reporting Official Guidelines when reporting the principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
- ✓ Review the Index of ICD-9-CM for Hospitals, Volumes 1, 2, and 3 and the ICD-9-CM Official Coding Guidelines for Coding and Reporting, available at http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html on the CMS website.

Resources: Other resources that may help avoid these errors include:

- The "Medicare Program Integrity Manual," Chapter 6, Section 6.5.3, DRG Validation Review, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf on the CMS website; and
- The ICD-9-CM addendums, which are available at http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html on the CMS website.

Recovery Audit Findings: MS-DRG Validation: Amputations MS-DRGs 239, 240, 241, 474, 475, and 476

Provider Types Affected: Inpatient Hospitals

Problem Description: 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, match both the attending physician description and the information contained in the beneficiary's medical record. Reviewers validated MS-DRGs 239, 240, 241, 474, 475, and 476 for principal and secondary diagnoses and procedures affecting or potentially affecting the MS-DRG assignment.

- MS-DRG 239 Amputation for Circulatory System Disorders Except Upper Limb & Toe with MCC
- MS-DRG 240 Amputation for Circulatory System Disorders Except Upper Limb & Toe with CC
- MS-DRG 241 Amputation for Circulatory System Disorders Except Upper Limb & Toe Without CC/MCC
- MS-DRG 474 Amputation for Musculoskeletal System and Connective Tissue Disorders with MCC
- MS-DRG 475 Amputation for Musculoskeletal System and Connective Tissue Disorders with CC
- MS-DRG 476 Amputation for Musculoskeletal System and Connective Tissue Disorders Without CC/MCC

Here are two examples of errors in billing:

Example 1: Medical record does not support secondary diagnosis
The patient is a 68-year-old male admitted with diabetic gangrene and had a transmetatarsal amputation. He had a pleural effusion that was tapped.

Finding: The provider assigned 428.31 (Diastolic Heart Failure; Acute) as a secondary diagnosis. The documentation in the medical record does not support assignment of code 428.31. The physician states in the progress notes "Diastolic Congestive Heart Failure (CHF)."

Therefore, code 428.31 has been removed from the claim and replaced with 428.30 (Diastolic Heart Failure, Unspecified). The change resulted in reassignment of the MS-DRG from 239 (Amputation for Circulatory System Disorders except Upper Limb and Toe with MCC) to MS-DRG 240 (Amputation for Circulatory System Disorders Except Upper Limb and Toe with CC).

Example 2: Medical record does not support secondary diagnosis
Patient is an 83-year-old male admitted with peripheral vascular disease and non-healing ulcer of the right foot. He was treated with a right above-the-knee amputation.

Finding: The provider assigned 584.9 (Acute Renal Failure; Acute Renal Failure, Unspecified) as a secondary diagnosis. The documentation in the medical record does not support the

assignment of 584.9 as a secondary diagnosis. Therefore, code 584.9 has been deleted from the claim. This change results in a reassignment of MS-DRG from 239 (Amputation for Circulatory System Disorders except Upper Limb and Toe with MCC) to 240 (Amputation for Circulatory System Disorders except Upper Limb and Toe with CC).

Guidance on how providers can avoid these billing errors:

- ✓ Review the documentation within the medical record and assign codes appropriately based on documentation.
- ✓ Review guidance in Coding Clinic for proper code assignment.
- ✓ Apply Official Guidelines for Coding and Reporting, Section III, Reporting Additional Diagnosis.
- ✓ Apply appropriate Official Guidelines for Coding and Reporting and Coding Clinics guidance for dates of service on the claim.

Resources: For additional information on avoiding these errors, you may want to review:

- The "Medicare Program Integrity Manual," Chapter 6, Section 6.5.3, DRG Validation Review, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf on the CMS website;
- The ICD-9-CM Coding Manual applicable to the dates of service; and
- The ICD-9-CM addendums, which are available at http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html on the CMS website.

Did you know...

Although the final rule on the proposed ICD-10 deadline change has yet to be published, it is important to continue planning for the transition to ICD-10. The switch to the new code set will affect every aspect of how your organization provides care, but with adequate planning and preparation, you can ensure a smooth transition for your practice. Keep Up to Date on ICD-10. Please visit the ICD-10 website for the latest news and resources to help you prepare.

Check out CMS on:

Twitter,

LinkedIn,

YouTube

ICN 909012/ July 2014