



Medicare Quarterly Provider Compliance Newsletter Guidance to Address Billing Errors

Volume 1, Issue 1 – October 2010



Official CMS Information for Medicare Fee-For-Service Providers

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Highlights of This Issue

Introduction

This is the first issue of a new Medicare Learning Network (MLN) educational product entitled the “Medicare Quarterly Provider Compliance Newsletter,” which is intended to help physicians, providers, and suppliers and their billing staffs understand how to avoid certain billing errors and other improper activities (such as failure to submit medical record documentation timely) when dealing with the Medicare Fee-For-Service (FFS) program.

The newsletter highlights, where appropriate, the consequences related to these billing errors or noncompliance with Medicare regulations and policies. It also provides summary information about claims processing, medical review, program integrity, and other compliance-related issues discovered as the Centers for Medicare & Medicaid Services (CMS) reviews activity and expenditures under the Medicare program, especially as those activities relate to FFS providers. The newsletter describes the issue, the problems that may occur as a result of the issue, the steps CMS has taken to make providers aware of the issue, and the recommendations on what providers need to do to avoid the problem. In addition, the newsletter refers providers to other documents for more detailed information where such documents exist.

In this first edition, CMS presents a number of issues that impact a variety of provider types as a way to introduce the product to a wide audience of providers. Future issues will focus on the “top” issues of that particular quarter; therefore, it may focus on a single provider type or a particular set of items or services. Many of the issues presented are uncovered as a result of reviews by the General Accountability Office and/or the Office of the Inspector General (OIG) in the U.S. Department of Health and Human Services. The issues are also identified by CMS activities and those of its contractors, such as the Recovery Audit Contractors (RACs), Program Safeguard Contractors, Zone Program Integrity Contractors, and Medicare Administrative Contractors (MACs).

The issues addressed in this newsletter are listed in the Table of Contents. You can navigate directly to a specific issue by placing your cursor on the issue in the Table of Contents and “left clicking.” In addition, all issues of the newsletter will be available via the CMS website so if a provider misses a particular issue, it will remain just a few clicks away on the Internet.

- Documentation Guidance for Hospitals and Skilled Nursing Facilities (pages 1 and 7)
- Correct Billing of Service Units (pages 2, 6, and 8)
- Correct diagnosis coding (pages 3 and 5)

Issue: Inpatient Hospitals and Skilled Nursing Facilities Fail to Submit Requested Documentation

Provider Types Affected: Hospitals, Skilled Nursing Facilities

Problem Description:

CMS has established, as mandated by law, a national RAC program as discussed in the introductory portion of this newsletter. One problem the RACs have identified is that some hospitals and skilled nursing facilities do not deliver documentation timely when CMS, a RAC, or other CMS contractor requests such documentation.

Claim payment decisions that result from a medical review of records are based on the documentation that Medicare contractors receive. For a Medicare claim to be paid, there must be sufficient documentation in the provider's records to verify that the services were provided to eligible beneficiaries; met Medicare coverage and billing requirements, including being reasonable and necessary;

were provided at an appropriate level of care; and were correctly coded. If there is insufficient documentation for the services billed, the claim may be considered an overpayment, and the provider may be requested to repay the payment to Medicare. Submission of incomplete or illegible medical records can also result in denial of payment for services billed.

Guidance on How Providers Can Avoid These Problems:

✓ CMS and its contractors conducted more than 100 national RAC outreach sessions during fiscal years 2009–2010 (FY09–FY10) to emphasize the importance of submitting timely documentation in response to Additional Documentation Request (ADR) letters.

✓ CMS published an MLN Matters® article on the issue with specific recommendations for providers. The article can be reviewed at <http://www.cms.gov/MLNMattersArticles/downloads/SE1024.pdf> on the CMS website.

Recommendations:

- ✓ CMS reminds providers that medical documentation must be submitted within 45 days of the date of the ADR letter.
- ✓ Remember that failure to submit medical records (unless an extension has been granted) results in denial of the claim.
- ✓ CMS recommends providers implement a plan of action for responding to RAC ADR letters.
- ✓ Providers should consider assigning a point of contact and, if necessary, an alternate, who will be responsible for tracking and responding to RAC ADR letters.
- ✓ Providers should tell the RAC the precise address and contact person to use when sending ADR letters.
- ✓ Providers should consult the individual RAC websites for more details. These websites are listed in the MLN Matters® article at <http://www.cms.gov/MLNMattersArticles/downloads/SE1024.pdf> on the CMS website.
- ✓ Providers should monitor these RAC websites periodically for updates on approved new issues.



Issue: Other Services with Excessive Units – Units Billed Exceeded the Number Approved per Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) Code Descriptions

Provider Types Affected: Outpatient Hospitals

Problem Description:

CMS established, as mandated by law, a national RAC program as discussed in the introductory portion of this newsletter. Although CMS, Affiliated Contractors (ACs), and MACs have undertaken actions to prevent future improper payments, it is difficult to prevent all improper payments, considering that more than 1 billion claims are processed each year. CMS uses the RAC program to detect and correct improper payments in the Medicare FFS program and to provide CMS, ACs, and MACs with information that could help protect the Medicare Trust Funds by preventing future improper payments.

Demonstration RACs determined that inpatient claims totaling almost \$10 million dollars were made for services exceeding what was approved for the related CPT/HCPCS code descriptions. In most cases, documentation was not sufficient to support the additional units billed.

Covered Indications and Documentation Requirements:

CMS requires providers to bill accurately using the appropriate CPT/HCPCS codes and to report units of service performed. In addition, CMS requires that providers maintain documentation to support the level of service billed.

Recommendations:

Providers should ensure that they use the appropriate CPT/HCPCS codes for the service/care performed and accurately report units of service/care performed. Providers should also maintain documentation to support

the level of service/care billed, and the volume of documentation should not be the primary influence upon which a specific level of service/care is billed. Documentation should support the level of service/care provided and reported, and the service/care should be documented during or as soon as practicable after it is provided to maintain an accurate medical record.



Issue: Inpatient Hospital Services – Respiratory System Diagnosis with Ventilator Support: Principal Diagnosis on the Claim Did Not Match the Principal Diagnosis in the Medical Record

Provider Types Affected: Inpatient Hospitals

Problem Description:

Demonstration RACs validated medical record documentation for DRG 475 – *Respiratory System Diagnosis with Ventilator Support*; MS-DRG 207 – *Respiratory System Diagnosis with Ventilator Support <96 Hours (formerly DRG 565)*; and MS-DRG 208 – *Respiratory System Diagnosis with Ventilator Support 96+ Hours (formerly DRG 566)* to determine if the principal diagnosis and all secondary diagnoses identified as complications and comorbidities (CC) and major complications and comorbidities (MCC) were actually present, correctly sequenced, and coded. These reviews determined that some inpatient claims were improperly submitted for respiratory system diagnoses with ventilator support because the principal diagnosis on the claim did not match the principal diagnosis identified in the medical record.

Documentation Requirement:

DRG validation requires that diagnostic and procedural information and a patient's discharge status, 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.

Further, the principal diagnosis and all secondary diagnoses identified as CC and MCC are actually present, correctly sequenced, and coded. When a patient is admitted to the hospital, the

condition that is chiefly responsible for requiring the admission to the hospital should be sequenced as the principal diagnosis. The other diagnoses identified should represent all (CC/MCC) present during the admission that impact the stay. Finally, the present on admission (POA) indicator for all diagnoses reported must be coded.

Recommendations:

To prevent payment denial, hospitals should ensure that:

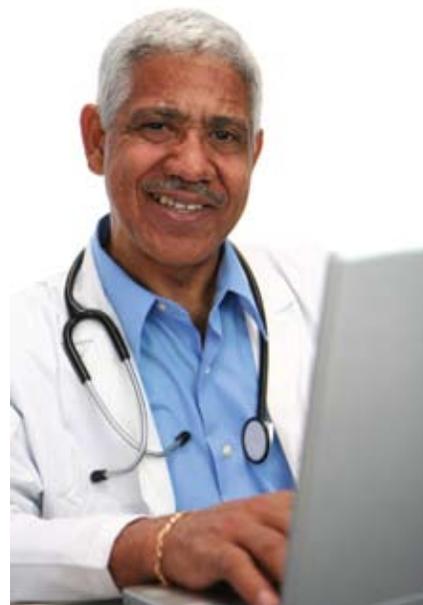
- ✓ The principal and secondary diagnosis codes and the procedure codes on the claim for DRG 475, MS-DRG 207 (formerly DRG 565), and MS-DRG 208 (formerly DRG 566) match the information in a patient's medical record.
- ✓ The principal diagnosis and all secondary diagnoses identified as CCs and MCCs are actually present, correctly sequenced, and coded.
- ✓ The condition chiefly responsible for a patient's admission to the hospital should be sequenced as the principal diagnosis, and the other diagnoses identified should represent all (CC/MCC) present during the admission that impact the stay.
- ✓ The POA indicator for all reported diagnoses is coded correctly.

In addition, you should consider:

- ✓ Developing a strategy within your organization to deal with a RAC medical record request. Make certain

there is one person and a backup in charge of monitoring the RAC process.

- ✓ Consulting the *Medicare Benefit Policy Manual* Chapter 15, Section 50.2, which may provide the information you need to make changes in charge capture, coding, and billing processes needed to be compliant with Medicare reporting requirements.
- ✓ Monitoring the RAC web portals, which contain detailed claims information about audit results. CMS published MLN Matters® article SE1024 with specific recommendations for providers about RAC websites. The article can be reviewed at <http://www.cms.gov/MLN MattersArticles/downloads/SE1024.pdf> on the CMS website.



Issue: Other Cardiac Pacemaker Implantation (DRG 116) – Not Medically Necessary to Receive Care in Inpatient Setting

Provider Types Affected: Inpatient Hospitals

Problem Description:

Reviews by Demonstration RACs identified that improper payments were made for inpatient claims totaling more than \$21 million dollars for cardiac pacemaker implantation care. Demonstration RACs determined that these services were not medically necessary in an inpatient setting.

Covered Indications and Documentation Requirements:

The *Medicare National Coverage Determinations (NCD) Manual* (Section 20.8) provides nationally covered and noncovered indications for single-chamber and dual-chamber cardiac pacemakers. All other indications for single-chamber and dual-chamber cardiac pacing, for which CMS has not specifically indicated coverage, remain nationally noncovered, except for Cat-

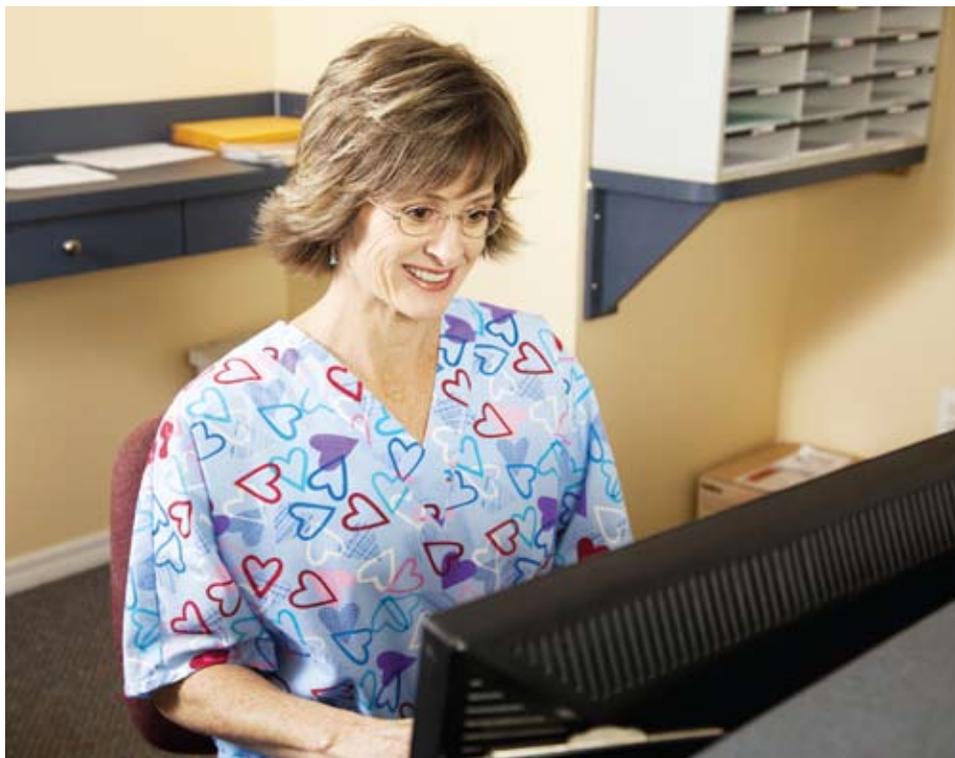
egory B Investigational Device Exemption clinical trials or as routine costs of single-chamber or dual-chamber cardiac pacing associated with clinical trials, in accordance with Section 310.1 of the *NCD Manual*.

Guidance on How Providers Can Avoid These Problems:

- ✓ CMS has provided Change Request 3444 (September 10, 2004, effective April 1, 2004) with details about changing the status of a hospital patient from inpatient to outpatient, which can be reviewed at <https://www.cms.gov/transmittals/downloads/R299CP.pdf> on the CMS website.

Recommendations:

- ✓ The Medicare *NCD Manual* (Chapter 1, Part 1, Section 20.8 (Cardiac Pacemakers) at http://www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf) can be reviewed on the CMS website.
- ✓ Remember that services must be reasonable and necessary and consider consulting Chapter 6 of the *Program Integrity Manual* at <http://www.cms.gov/manuals/downloads/pim83c06.pdf> on the CMS website.



Issue: Inpatient Hospital Services – Heart Failure and Shock (DRG 127) Criteria for Inpatient Care Not Met

Provider Types Affected: **Hospitals**



Problem Description:

CMS established, as mandated by law, a Demonstration RAC program. Reviews by Demonstration RACs determined that inpatient claims for heart failure and shock totaling more than \$34 million dollars were made after medical record review revealed that the documentation submitted did not support an inpatient level of care.

Guidance on How Providers Can Avoid These Problems:

- ✓ CMS implemented a *Program Integrity Manual* instruction (December 21, 2009) that requires claims processing contractors to use vulnerabilities identified through the RAC program to identify where to target their improper payment prevention efforts.

Recommendations:

In addition, you should consider:

- ✓ Reviewing Chapter 6, Section 6.5 (Medical Review of Inpatient Hospital Claims) of the *Program Integrity Manual*, which is available at <http://www.cms.gov/manuals/downloads/pim83c06.pdf> on the CMS website.
- ✓ Monitoring the RAC web portals, which contain detailed claims information and guidance on audit findings. CMS published MLN Matters® article SE1024 with specific recommendations for providers about RAC websites. The article can be reviewed at <http://www.cms.gov/MLN MattersArticles/downloads/SE1024.pdf> on the CMS website.
- ✓ Developing a strategy within your organization to deal with a RAC medical record request. Make certain that there is one person and a backup in charge of monitoring the RAC process.

Issue: Other Drug Codes – Incorrect Number of Units Billed

Provider Types Affected: **Outpatient Hospital**

Problem Description:

Reviews by Demonstration RACs determined that excessive/multiple units comprised many of the billing errors made by outpatient hospitals, and those errors totaled more than \$2 million dollars. In most cases denials occurred because documentation was not sufficient to support the units billed.

Guidance on How Providers Can Avoid These Problems:

✓ CMS published MLN Matters® article 6857 that describes changes to and billing instructions for various payment policies implemented in the April 2010 Outpatient Prospective Payment System update. MM6857 can be reviewed at <http://www.cms.gov/MLN MattersArticles/downloads/MM6857.pdf> on the

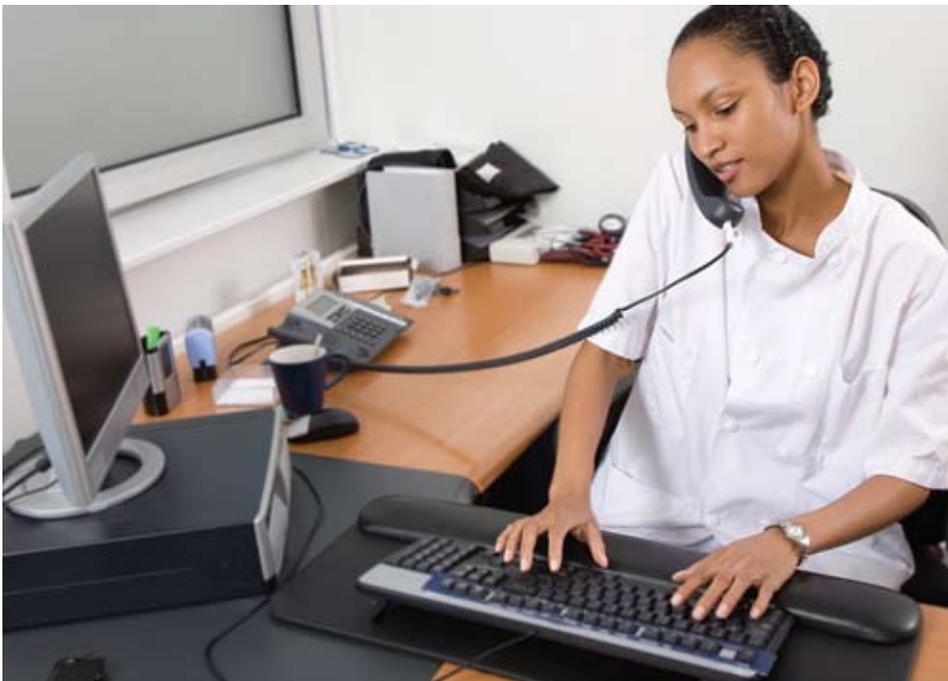
CMS website. This article highlights correct coding of drugs. In the article, hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor.

- ✓ Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, hospitals should bill 10 units, even though only 1 vial was administered. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture

the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

Recommendations:

- ✓ Pay close attention to accurate billing for units of service consistent with the dosages contained in the new long descriptors of the active HCPCS codes.
- ✓ Monitor RAC web portals that contain detailed claims information and audit results. CMS published an MLN Matters® article with specific recommendations for providers about RAC websites. The article can be reviewed at <http://www.cms.gov/MLN MattersArticles/downloads/SE1024.pdf> on the CMS website.



Issue: Inpatient Hospital Services – Medical Record Did Not Include Sufficient Documentation

Provider Types Affected: Hospitals

Problem Description:

Reviews by Demonstration RACs determined that certain inpatient claims totaling more than \$63 million dollars were made with insufficient documentation submitted.

The following example is extracted from the OIG report of July 2010, which can be reviewed at <http://oig.hhs.gov/oas/reports/region1/11001000.pdf> on the Internet. A hospital was paid for total hip replacement surgery. Medicare concluded that the documentation in the beneficiary's medical record was insufficient to support the need for the surgery. Specifically, the record did not contain information on the types of treatment that had been tried before surgery, a pathology note to support statements in the record, or a preoperative x-ray documenting the extent of osteoarthritis of the hip. As a result, payment was denied.

Guidance on How Providers Can Avoid These Problems:

- ✓ CMS educated providers about the importance of submitting timely documentation in response to ADRs at Hospital Association Presentations during FY07 and FY08 and during RAC outreach sessions between FY09–FY10.

Recommendations:

- ✓ Remember that failure to submit medical records (unless an extension is granted) results in denial of the claim. Such failure is tantamount to the medical record not supporting the procedure/service performed.
 - ✓ CMS recommends providers implement a plan of action for responding to RAC ADR letters.
 - ✓ Providers should consider assigning a point of contact and, if necessary, an alternate, who will be responsible for tracking and responding to RAC ADR letters.
- ✓ Providers should tell the RAC the precise address and contact person to use when sending ADR letters.
 - ✓ Providers should consult the individual RAC websites for more details. These websites are listed in the MLN Matters® article at <http://www.cms.gov/MLN MattersArticles/downloads/SE1024.pdf> on the CMS website.
 - ✓ Providers should monitor these RAC websites periodically for updates on approved new issues.



Issue: Physician Pharmaceutical Injectables – Incorrect Procedure Codes and/or Number of Units Billed

Provider Types Affected: Physicians

Problem Description:

CMS uses the RAC program to detect and correct improper payments in the Medicare FFS program and provides information to CMS, ACs, and MACs that could help protect the Medicare Trust Funds by preventing future improper payments. Incorrect coding of pharmaceutical injectables, excessive/multiple units, Neulasta® (medically unnecessary), vestibular function testing, and duplicate claims were among the most common reasons found for physician overpayments in the June 2008 RAC Demonstration Report.

Reviews by Demonstration RACs indicated that claims were paid for pharmaceutical injectables with an incorrectly billed number of units; claims paid incorrectly by fee schedule and drugs billed under incorrect HCPCS codes totaled more than \$5 million dollars.

Guidance on How Providers Can Avoid These Problems:

- ✓ CMS published MLN Matters® article 6950, which describes injectable drugs, including intravenously administered drugs typically eligible for inclusion under the “incident to” benefit. MM6950 can be reviewed at <http://www.cms.gov/MLNMaterialsArticles/downloads/MM6950.pdf> on the CMS website.
- ✓ Drug coverage is discussed in Chapter 17 of the *Medicare Claims Processing Manual* (<http://www.cms.gov/manuals/downloads/clm104c17.pdf>), especially Section 40 (Discarded Drugs and Biologicals), Section 70 (Claims Processing Requirements – General), and Section 80 (Claims Processing for Special Drug Categories).

Recommendations:

- ✓ Be sure staff is aware of the manual chapter and article cited previously regarding Medicare policy on billing for drugs.
- ✓ Ensure you adequately document a physician’s drug orders, dosage administered, and when required by CMS policy, the drug dosage wasted amount.



