

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



Official CMS Information for  
Medicare Fee-For-Service Providers

# Medicare Quarterly Provider Compliance Newsletter

## Guidance to Address Billing Errors



Volume 1, Issue 4 - July 2011

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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 process more than 1 billion claims each year, submitted by more than 1 million providers, including hospitals, physicians, Skilled Nursing Facilities, clinical laboratories, ambulance companies, and suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). These contractors, called “Medicare claims processing contractors,” process claims, make payments to health care providers in accordance with Medicare regulations, and educate providers regarding 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. In the Tax Relief and Health Care Act of 2006, the U.S. Congress authorized the expansion of the Recovery Audit Program nationwide by January 2010 to further assist the Centers for Medicare & Medicaid Services (CMS) in identifying improper payments. Medicare FFS Recovery Auditors are contractors that assist CMS by performing claim audits on a post-payment basis.

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, and other governmental organizations, such as the Office of Inspector General. This is the fourth issue of the newsletter and 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, such as failure to submit timely medical record documentation, when dealing with the Medicare FFS program. An archive of previously issued newsletters is also available to providers in case they missed one. This archive can be found at [http://www.cms.gov/MLNProducts/downloads/MedQtrlyCompNL\\_Archive.pdf](http://www.cms.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf) on the CMS website.

The newsletter describes the problem, the issues that may occur as a result, the steps CMS has taken to make providers aware of the problem, and guidance on what providers need to do to avoid the issue. In addition, the newsletter refers providers to other documents for more detailed information wherever they may exist.

The findings addressed in this newsletter are listed in the Table of Contents and can be navigated to directly by “left-clicking” on the particular issue in the Table of Contents. A searchable index of keywords and phrases contained in both current and previous newsletters can be found at [http://www.cms.gov/MLNProducts/downloads/MedQtrlyCompNL\\_Index.pdf](http://www.cms.gov/MLNProducts/downloads/MedQtrlyCompNL_Index.pdf) on the CMS website.

## Recovery Audit Finding: Multiple Durable Medical Equipment (DME) Rentals per Month

**Provider Types Affected:** DME, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

**Problem Description:** Data analysis of DMEPOS claims was conducted for selected codes on the DMEPOS fee schedule assigned with the following categories:

- ✓IN – Inexpensive/routinely purchased DME
- ✓FS – Frequency Service DME
- ✓CR – Capped Rental DME
- ✓OX – Oxygen and Oxygen Equipment OXY

Overpayments associated with DMEPOS suppliers billing multiple rentals for the same equipment within the same month were identified.

Here are two examples of suppliers billing multiple rentals for the same equipment within a single month.

**Example 1:** A supplier for Beneficiary A billed E1390-RR (Oxygen concentrator, single delivery port, capable of delivering 85% or greater oxygen concentration at the prescribed flow rate) on 10/26/2007. The same supplier for Beneficiary A billed E1390-RR on 11/3/2007.

**Finding:** Nine days between billings is considered to be an overpayment.

**Example 2:** A supplier for Beneficiary B billed E0776-RR-BA (IV pole) on 10/31/2007. The same supplier for Beneficiary B billed E0776-RR-BA on 11/1/2007.

**Finding:** One day between billings is considered to be an overpayment.

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

- ✓Payment for rentals for certain DME is made on a monthly basis. Within a single month, only one rental payment may be paid for the same item; the billing of additional rentals for the same item within the same overlapping time period represents an overpayment. The DME contractor will count as a month, the date the oxygen equipment was initially furnished to the day before the same date in the following month and each rental month thereafter until the 36th month anniversary is reached. More information is available in the “Medicare Claims Processing Manual,” Chapter 20–Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), Section 130.6, Billing for Oxygen and Oxygen Equipment, which can be found at <http://www.cms.gov/manuals/downloads/clm104c20.pdf> on the CMS website.

- ✓For help with completing your claims correctly, please review the Supplier Manual from the DME Medicare Administrative Contractor (MAC) that processes your claims. A listing of DME MAC Supplier manuals for the following contractors can be found on the DME Center web page at <http://www.cms.gov/center/dme.asp> under the

“Important Links, Billing and Payment” section:

- **NHIC** – Region A
- **National Government Services** – Region B
- **Cigna Government Services** – Region C
- **Noridian Administrative Services** – Region D



## Recovery Audit Finding: Acute Respiratory Failure

### Provider Types Affected: Inpatient Hospitals

**Problem Description:** Recovery Auditors validated Medicare Severity-Diagnosis Related Group (MS-DRG) 189 (Respiratory Failure), specifically the principal diagnosis and any secondary diagnoses affecting or potentially affecting the DRG. The purpose of this study was to determine that the principal diagnosis and all secondary diagnoses identified were actually present, correctly sequenced, coded and clinically validated. When a patient is admitted to the hospital, the condition established after study found to be chiefly responsible for occasioning the admission to the hospital should be sequenced as the principal diagnosis. The other diagnoses identified should represent diagnoses present during the admission that impact the stay. The Present on Admission (POA) indicator for all diagnoses reported must be coded correctly.

The following examples give reasons for adjustments to codes and MS-DRGs in order to align provider payments with Medicare guidelines for the presence of diagnoses and to ensure diagnoses are correctly sequenced, coded, and clinically validated.

**Example 1:** A 78-year-old female was re-admitted through the emergency department with hypoxemia and hypercarbia. Her Continuous Positive Airway Pressure (CPAP) or Bilevel Positive Airway Pressure (BiPAP) was inappropriately applied without oxygen. Patient presented with a chief complaint of shortness of breath with an Emergency Department (ED) impression of respiratory distress, sarcoidosis, and early Congestive

Heart Failure (CHF). The admitting physician documents on the History & Physical (H&P) an admission diagnosis of panic attack, hypoxemia, hypercarbia, sleep-disordered breathing, renal insufficiency, and anemia. History of present illness states that patient was discharged home on Friday afternoon and then re-admitted this morning. She has a history of interstitial infiltrates and sarcoidosis, chronic anemia and renal insufficiency. Discharge summary lists the final diagnosis as hypoxemia, dyspnea, anxiety, anemia, and shingles.

**Auditor Finding:** There is no physician documentation of acute respiratory failure.

**Action:** The auditor deleted respiratory failure code 518.81 and changed the principal diagnosis to hypoxemia code 799.02. This resulted in a MS-DRG change from 189 to 206—Other Respiratory System Diagnoses without Major Complication and Comorbidity (MCC). These changes resulted in an overpayment.

**Example 2:** An 81-year-old female was admitted with complaints of dry cough for a couple of weeks. The patient was admitted through the emergency department and was assessed for wheezing and coughing. H&P impression is acute respiratory failure secondary to exacerbation of Chronic Obstructive Pulmonary Disease (COPD). Progress notes through the stay also document the diagnosis of acute respiratory failure secondary to exacerbation of COPD. Final diagnosis on the discharge summary is acute respiratory failure secondary to COPD exacerbation.

Additional documentation sheet supplied in the record list the patient's diagnoses as: Principal Diagnosis: COPD exacerbation; Other Diagnoses: high blood pressure, Coronary Artery Disease (CAD), Congestive Heart Failure (CHF), Diabetes Mellitus (DM), Parkinson's, and rheumatoid arthritis.

**Auditor finding:** After physician and auditor review, it was determined that the clinical evidence in the medical record did not support respiratory failure, despite physician documentation of the condition.

**Action:** The auditor deleted acute respiratory failure and changed the principal diagnosis to COPD Exacerbation. The auditor deleted respiratory failure code 518.81 and changed the principal diagnosis to hypoxemia code 799.02. This resulted in a MS-DRG change from 189 to 192—Chronic Obstructive Pulmonary Disease without CC/MCC. This change resulted in an overpayment.

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

- ✓ 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 affect the stay. Code only those conditions documented by the physician.
- ✓ Refer to the coding clinic guidelines and query the physician when clinical validation is required. Also, inquire about conflicting documentation.

# Recovery Audit Finding: Gastroenteritis with Hemorrhage with Complication and Comorbidity (CC) or Major Complication and Comorbidity (MCC)

**Provider Types Affected:** Inpatient Hospitals

## Problem Description:

Recovery Auditors performed DRG validation on the following MS-DRGs:

- ✓ MS-DRG 377–G.I. hemorrhage with MCC
- ✓ MS-DRG 378–G.I. hemorrhage with CC
- ✓ MS-DRG 379–G.I. hemorrhage without CC/MCC

The purpose of this MS-DRG Validation study was to determine whether the principal diagnosis and all secondary diagnoses identified as CC and MCC were actually present, correctly sequenced, coded and clinically validated. When a patient is admitted to the hospital, the condition established after study found to be chiefly responsible for occasioning the admission to the hospital should be sequenced as the principal diagnosis. The other diagnoses identified should represent all MCCs/CCs present during the admission that impact the stay. The Present on Admission (POA) indicator for all diagnoses reported must be coded correctly.

The following example gives reasons for adjustments to codes and MS-DRGs in order to align provider payments with Medicare guidelines for the presence of diagnoses and to ensure diagnoses are correctly sequenced, coded, and clinically validated.

**Example:** A 65-year-old male was noted to be anemic during dialysis and sent to the Emergency Department (ED) from the dialysis unit for further evaluation and

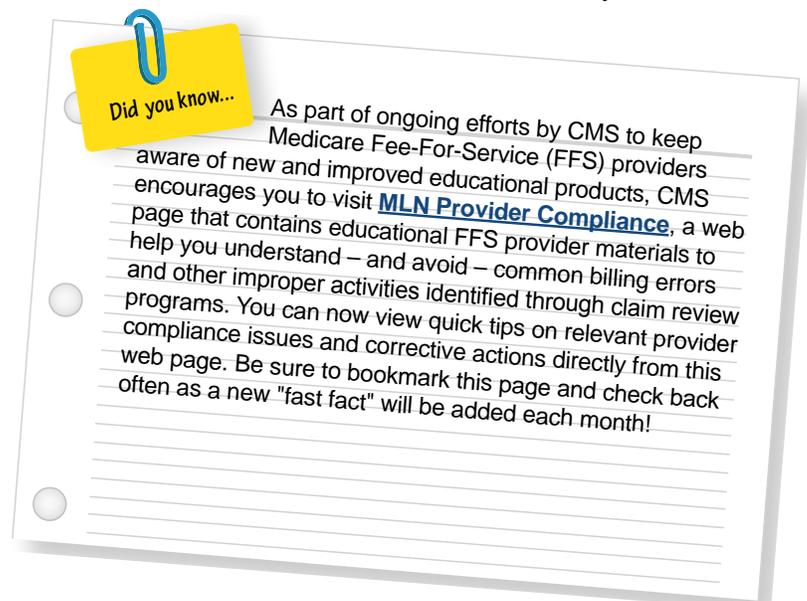
treatment. Patient had a prior workup for Gastrointestinal (GI) bleed which was not conclusive. Patient was treated with transfusion. The admitting diagnosis was anemia. The ED physician documentation states the patient has not noticed any melena or hematochezia. GI consult states the patient was admitted with anemia and that the patient denied any GI complaints and denies any recent GI bleed. GI consult assessment is anemia with no evidence of GI bleed. Progress notes state the anemia is an iron deficiency anemia. Discharge summary final diagnostic statement is anemia with End-Stage Renal Disease (ESRD).

**Auditor Finding:** There is no physician documentation within the record supplied for the diagnosis of blood in stool. Coding a prior condition that is no longer present or that has resolved prior to the current admission is incorrect.

**Action:** The principal diagnosis was changed to iron deficiency anemia. This change resulted in an MS-DRG change from 377–GI Hemorrhage with MCC to 811–Red blood cell disorders with MCC. This resulted in an overpayment.

## Guidance on How Providers Can Avoid These Problems:

- ✓ 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 affect the stay. Code only those conditions documented by the physician. Other identified diagnoses should represent all MCCs and CCs present during the admission that affect the hospital stay. In addition, the POA indicator for all diagnoses reported (both principal and secondary) must be coded correctly.



- ✓ All medical documentation entries must be consistent with other parts of the medical record (assessments, treatment plans, physician orders, nursing notes, medication and treatment records, etc.); and with other facility documents such as admission and discharge data and pharmacy records. If an entry is made that contradicts documentation found elsewhere in the record, clarification should be obtained and documented by the attending physician.
- ✓ The hospital's claim must match both the attending physician's description/diagnosis and the information contained in the beneficiary's medical record.
- ✓ Review the "ICD-9-CM Coding Manual" and the "ICD-9-CM Addendums and Coding Clinics" about coding guidelines on sequencing and selection of principal diagnosis. Follow coding guidelines and Uniform Hospital Discharge Data Set (UHDDS) definitions of when to code secondary diagnosis and chronic conditions. Do not code diagnoses not documented in the record.
- ✓ View the UB-04 web-based training course for more information about the UB-04 form. To access this course, visit <http://www.cms.gov/MLNProducts> and click on "Web-Based Training Modules" under the "Related Links Inside CMS" section.



## Recovery Audit Finding: Major Cardiovascular Thoracic Aortic Aneurysm Repair Procedures with CC or MCC.

**Provider Types Affected:** Inpatient Hospitals

**Problem Description:** Recovery Auditors performed Diagnosis-Related Group (DRG) validation on Medicare Severity-Diagnosis Related Group (MS-DRG) 237.

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

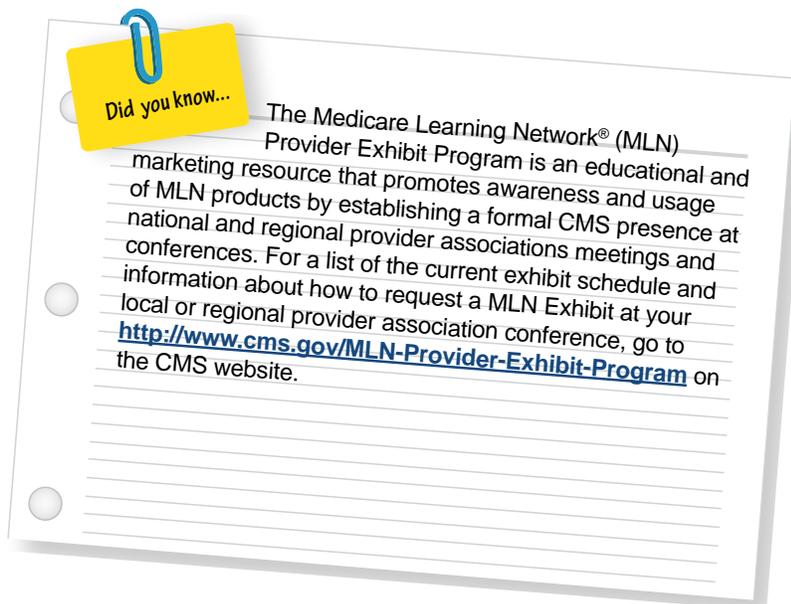
**Example 1:** A 75-year-old male, admitted with past medical history of coronary artery disease with previous quadruple bypass and previous Percutaneous Transluminal Coronary Angioplasty (PTCA) in 2003 and 2007, presents for consideration of angioplasty. Cardiac catheterization was performed with successful PTCA of the Saphenous Vein Graft (SVG) to the Right Posterior Descending Artery (RPDA) and an unsuccessful PTCA of the SVG to the OM2. During the second stent deployment, the patient became very hypotensive and bradycardiac, was intubated, and expired. The operative report has a documented diagnosis of respiratory arrest. No diagnoses are listed on expiration summary. Hospital course is documented. Patient expired during PTCA.

**Auditor Finding:** Acute respiratory failure was coded by the provider. After review of the medical record submitted no physician documentation of acute respiratory failure was present. The operative report has a documented diagnosis of respiratory arrest.

**Action:** The code 518.81 (acute respiratory failure) was deleted and the code 799.1 (respiratory arrest) was added to the claim. This changed the DRG from 237 - Major Cardiovascular Procedures with MCC or Thoracic Aortic Aneurysm Repair to 238-Major Cardiovascular Procedure w/o MCC.

**Example 2:** A 72-year-old male was admitted through the ED with a pressure sensation in the lower chest. The impression documented by the ED physician was Acute Myocardial Infarction. During the admission the patient had an emergent left heart catheterization and angioplasty performed. During the angioplasty procedure, the patient expired. Operative report: "Left Heart... Cath Preoperative diagnosis of acute myocardial infarction. Showed severe CAD...Angioplasty report...Preoperative diagnosis of acute myocardial infarction." During the angioplasty procedure the patient arrested and expired. No discharge summary present.

**Auditor Finding:** The provider coded the coronary artery disease as principal diagnosis. According to coding clinic 2<sup>nd</sup> quarter 2001 and the definition of principal diagnosis, the acute myocardial infarction should

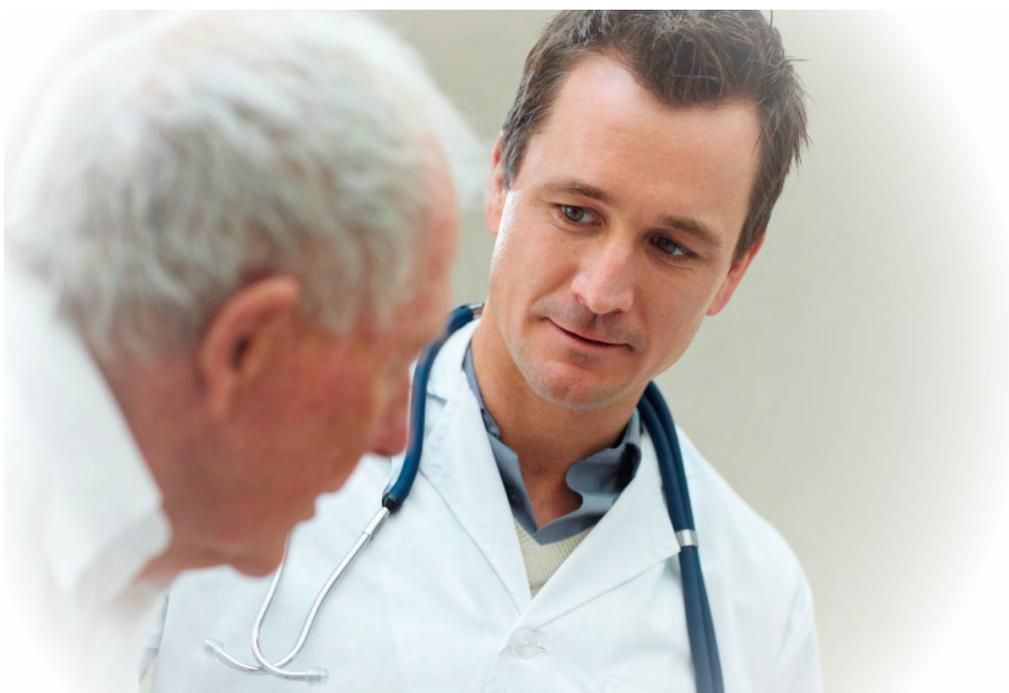


have been sequenced as principal diagnosis with an additional code for the coronary artery disease.

**Auditor Action:** In re-sequencing the diagnosis codes of 410.91 (acute myocardial infarction) to principal diagnosis and 414.01 (coronary artery disease) as a secondary diagnosis, the DRG changed from 237 to 238.

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

- ✓ When a patient is admitted to the hospital, the health condition that (after physician assessment) is determined to be chiefly responsible as the cause for the admission should be sequenced as the principal diagnosis (coded as an MS-DRG). Review the official coding guidelines for selection of principal diagnoses and chapter specific guidelines. Refer to coding clinics for advice and guidance
- ✓ All medical documentation entries must be consistent with other parts of the medical record (assessments, treatment plans, physician orders, nursing notes, medication and treatment records, etc.); and with other facility documents such as admission and discharge data and pharmacy records. If an entry is made that contradicts documentation found elsewhere in the record, clarification should be obtained and documented by the attending physician.
- ✓ Review the “ICD-9-CM Coding Manual” and the “ICD-9-CM Addendums and Coding Clinics” about coding guidelines on sequencing and selection of principal diagnosis. Follow coding guidelines and Uniform Hospital Discharge Data Set (UHDDS) definitions of when to code secondary diagnosis and chronic conditions. Do not code diagnoses not documented in the record.



## Recovery Audit Finding: Intracranial Hemorrhage or Cerebral Infarction

**Provider Types Affected:** Inpatient Hospitals

**Problem Description:** Recovery Auditors performed DRG validation on MS-DRG 061 through 069, inclusive, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the MS-DRG. The purpose of MS-DRG Validation is to determine 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.

Office of Inspector General (OIG) Report OA1-09-86-00052 (January 1998) found an overwhelming majority of errors and assignment for DRG 14, now MS-DRG 064, 065, and 066.

- ✓064 Intracranial Hemorrhage or Cerebral Infarction With MCC
- ✓065 Intracranial Hemorrhage or Cerebral Infarction with CC
- ✓066 Intracranial Hemorrhage or Cerebral Infarction Without CC/MCC

The auditors have noted that the coding for CC and MCC of hemiparesis is often miscoded in both directions (i.e., not coded when there is sufficient documentation to code it and coded with insufficient documentation). Many records lack concise documentation to support either the diagnosis of Transient Ischemic Attack (TIA) or Cerebrovascular Accident

(CVA). The documentation states TIA vs. CVA. Due to the lack of documentation, the potential for errors is for providers to assign a principal diagnosis of CVA or TIA, but the documentation is not specific enough to support either one. Below is an example of incorrect coding.

**Example:** The patient is an 82-year-old female patient who comes to the Emergency Room with a TIA vs. CVA. The patient was noted to have decreased vision, double vision, and loss of balance. On examination, the patient was noted to have right hemiparesis and neurologic deficit due to acute CVA. MRA examination showed one 2 cm. aneurysm and acute CVA near the brain. The patient continued to have hemiparesis throughout the hospital stay as noted in the progress notes, neurological evaluation, and physical therapy assessment. The patient's discharge instructions were home with Occupational Therapy (OT) and Physical Therapy (PT).

The patient was found to have an acute CVA and the patient's physician documentation supports the principal diagnosis code of 434.9 (cerebral artery occlusion with cerebral infarction). The physician documents right hemiparesis on the progress notes as a neurologic deficit due to the CVA. Code 342.90—(hemiplegia, unspecified) should be assigned as additional diagnosis. The physician documents the hemiparesis was not resolved by the time of discharge, but has improved.

**Auditor Finding:** The addition of the hemiparesis changes the MS-DRG 66 (intracranial hemorrhage or cerebral infarction without CC) to MS-DRG 65 (intracranial hemorrhage or cerebral infarction with CC), resulting in an underpayment.

Did you know...

Medicare Fee-For-Service (FFS) and its business associates will implement the ASC X12, version 5010, and the National Council for Prescription Drug Program's (NCPDP) version D.0 standards as of January 1, 2012. To facilitate the implementation, Medicare has designated Calendar Year 2011 as the official 5010/D.0 transition year. As such, Medicare Administrative Contractors (MACs) will be testing with their trading partners throughout Calendar Year 2011. Medicare encourages its providers, vendors, clearinghouses, and billing services to schedule testing with their local MAC as soon as possible. CMS also encourages you to stay current on 5010/D.0 news and helpful tools by visiting <http://www.cms.gov/Versions5010andD0> on its website. **Test early, Test often!**

## Guidance on How Providers Can Avoid These Problems:

- ✓ Review the official coding guidelines for selection of principal diagnosis and chapter specific guidelines for the issue. Refer to coding clinics for advice and guidance.
- ✓ Review the entire medical record, the discharge planning note, OT and PT notes and any neurological consults. Identify documentation deficits and the need to query the physician.
- ✓ Review the entire medical record, the discharge planning note, OT and PT notes and any neurological consults. Identify documentation deficits and the need to query the physician.
- ✓ Review the “ICD-9-CM Coding Manual” and the “ICD-9-CM Addendums and Coding Clinics” about coding guidelines on sequencing and selection of principal diagnosis. Follow coding guidelines and Uniform Hospital Discharge Data Set (UHDDS) definitions of when to code secondary diagnosis and chronic conditions. Do not code diagnoses not documented in the record.
- ✓ Review the AHA Coding Clinic™, 3rd Quarter 1997, Page 11, Embolic hemorrhagic infarct of temporal lobe, for more information on this issue.



## Recovery Audit Finding: Post Operative Anemia

### Provider Types Affected: Inpatient Hospitals

**Problem Description:** Recovery Auditors performed DRG validation on MS-DRGs 467 (Revision of hip or knee replacement w CC), 481 (Hip and femur procedures except major joint with CC), 486 (Knee Procedures with Principal Diagnosis of Infection with CC), and 488 (Knee Procedures without Principal Diagnosis of Infection with CC/MC), principal diagnosis, secondary diagnosis, and procedures potentially affecting the DRG.

The purpose of MS-DRG Validation is to determine that the principal diagnosis, procedures 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 established after study found to be chiefly responsible for occasioning the admission to the hospital should be sequenced as the principal diagnosis. The other diagnosis identified should represent all MCC/CC present during the admission that will affect the stay. The POA indicator for all diagnoses reported must be coded correctly.

In the following examples, both patients experienced post-operative anemia, which was not documented as acute blood loss or due to blood loss. In both cases, the anemia was incorrectly coded as acute post-hemorrhagic anemia.

**Example 1:** An 83-year-old male was admitted after he slipped and fell on his left side. Patient was unable to ambulate and had severe pain. Radiology showed a

left acute intertrochanteric fracture. H&P documents an assessment and plan of hip fracture after mechanical fall, orthopedics aware and anticipate surgery. An open reduction internal fixation was performed for the hip fracture. No estimated blood loss documented within the documentation provided. Documentation in the progress notes and discharge summary documented the patient as having postoperative anemia. The patient's lowest hemoglobin was 8.2 on postoperative day one. Patient did receive 2 units of packed red blood cells.

**Auditor Finding:** Per coding clinic guidelines, postoperative anemia codes to 285.9 when not specified as due to acute blood loss. Therefore, 285.1—Acute post-hemorrhagic anemia was changed to 285.9—Anemia, unspecified. This caused a change in DRG from 481—Hip & Femur Procedures except Major Joint with CC to 482—Hip & Femur Procedures Except Major Joint Without CC/MCC.

**Example 2:** A 66-year-old male was admitted for surgery secondary to malunion of the left femur status post intertrochanteric hip fracture. The operative note has a pre- and postoperative diagnosis of malunion of left femur and the operative procedure was hardware removal deep to the bone with conversion of prior surgery to total hip replacement. Patient had an estimated blood loss of 1500cc with 1200cc cell saver and 600cc transfused back to the patient. Laboratory results show

lowest hemoglobin of 8.2 on postoperative day one. Progress notes on postoperative days one, two, and three only have a diagnosis of Postoperative anemia. Patient did have 2 units of packed red blood cells. Discharge summary does not have a final diagnosis of anemia; in fact, there is no mention of the anemia within the discharge summary.

**Auditor Finding:** Per Coding Clinic, first quarter, 2007, postoperative anemia without specification of acute blood loss codes to 285.9. Therefore, Code 285.1 Acute post hemorrhagic anemia is changed to 285.9 Post-operative anemia. This will change the DRG from 467—Revision of Hip or Knee Replacement With CC to 468—Revision of Hip or Knee Replacement Without CC/MCC.

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

- ✓ Become familiar with the coding clinics on acute blood loss anemia code 285.1. Ensure that there is proper documentation in the medical record to justify the use of this code. Query the physician if there is a lack of sufficient documentation.
- ✓ Review the ICD-9-CM coding manual, addendums and coding clinics to ensure accurate coding of diagnoses presented in the medical record.

## Recovery Audit Finding: Other Vascular Procedures with MCC: MS-DRG 252

**Provider Types Affected:** Inpatient Hospitals

### **Problem Description:**

Recovery Auditors performed DRG validation on Medicare Severity Diagnosis–Related Group (MS-DRG) 252–Other vascular procedures with major complication or comorbidity (MCC).

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 assigned MS-DRG of 252 did not have sufficient documentation to support this MS-DRG. Reviewers validated for MS-DRG 252 (previously DRG 479, 553 and 554), principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG.

Here are two examples where MS-DRG 252 was coded incorrectly.

**Example 1:** An 85 year old female presented with acute onset of bilateral lower extremity pain. The patient was found to have occlusion due to bilateral arterial thrombus. She has a past medical history of hypertension, coronary artery disease, hypothyroidism, pancreatitis, and osteoarthritis of the shoulder.

### **Past medical history:**

hypertension, coronary artery disease, hypothyroidism, pancreatitis, arthritis of shoulder.

### **Physical examination:**

documented normal except lower extremity vascular exam. Femoral pulse 2+ bilaterally, popliteal right strong doppler signal, left weak doppler study, right posterior tibial/ dorsalis pedis strong signal, left posterior tibial/dorsalis pedis weak sign. The patient had an aorto-femoral runoff angiogram that revealed left common femoral occlusion and right distal profunda. The patient was taken to the operating room for left thromboembolectomy. Patient was starting on heparin drip, and then was changed to lovenox. No complications were documented.

### **Auditor Finding:**

The original principle diagnosis of atherosclerosis of extremities, unspecified (440.20), was incorrect, upon complete review of the medical record. The arterial embolism and thrombosis of lower extremity was more appropriate (444.22). Pancreatitis was coded as a secondary diagnosis, when the patient only has a history of pancreatitis.

**Action:** Principal diagnosis code 440.20 (atherosclerosis of extremities, unspecified) was changed to 444.22 (arterial embolism and thrombosis of lower extremity). The procedure code 38.18 (endarterectomy of lower

limb artery) was changed to 38.08 (thrombectomy of lower limb artery) per medical record documentation.

The secondary diagnosis code 577.0 (acute pancreatitis) is deleted as the patient only has a history of acute pancreatitis and documentation did not support this diagnosis for this admission. DRG is changed from DRG 252 to DRG 254 (Other vascular procedures with cc/mcc). Overpayment is noted.

**Example 2:** The patient is a 78-year old male who presented with atypical chest pain and shortness of breath. The patient has a medical history significant for aortic valve stenosis, aortic aneurysm, renal artery stenosis, and hypertension.



Past medical history: aortic stenosis, aortic aneurysm, renal artery stenosis, hypertension, chronic atrial fibrillation, atrial-ventricular block with pacemaker.

**Physical examination:** CV-HRRR with 3/6 systolic murmur. Lungs, bibasilar crackles. Extremities—no edema.

The patient had an echocardiogram for his shortness of breath, which revealed an ejection fraction of 45% and moderate-severe aortic regurgitation. The patient also received an angiogram and stenting of the left renal artery with a bare metal stent. The right renal artery showed resolved right renal artery stenosis with stenting.

**Auditor Finding:** Acute chronic systolic heart failure (428.23) was coded as an additional diagnosis; however, documentation does not support the diagnosis. Documentation supports congestive heart failure, NHYA II (428.0) as additional diagnosis. Insertion of drug-eluting stent (00.55) into the renal artery was coded; however, documentation does not support that a drug-eluting stent was inserted. Documentation supports bare-metal stent (39.90) inserted into the renal artery.

**Action:** These changes resulted in the DRG being changed from 252 to 254 (other vascular procedures with cc/mcc). An overpayment is noted.

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

Coders should always follow the ICD-9 Official Coding Guidelines for Coding and Reporting when selecting the principal diagnosis, as well as the appropriate Coding Clinics specific to the diagnosis and procedure codes to best describe the scenario.

- ✓ Review the complete medical record and use the most appropriate diagnosis to code the claim.
- ✓ Ensure that there is documentation in the medical record to support the codes selected.
- ✓ Review Coding Clinic, 1<sup>st</sup> Quarter 2009, page 7: Diastolic or Systolic Dysfunction without Heart Failure:
  - A diagnosis of systolic or diastolic dysfunction is not coded the same as heart failure.
  - Diastolic dysfunction without mention of heart failure is indexed to 429.9, Heart

disease, unspecified. It is not appropriate to assume a patient is in heart failure, when only “diastolic dysfunction” or “systolic dysfunction” is documented.

- ✓ Coding Clinic 1<sup>st</sup> Quarter 1993, page 19: A diagnosis of congestive heart failure due to diastolic dysfunction due to hypertension should be coded as 402.91, Hypertensive heart disease, unspecified, with congestive heart failure. No additional code for the diastolic dysfunction is necessary.

If the diagnostic statement lists only diastolic dysfunction, assign code 429.9, Heart disease, unspecified, as the index now directs:

- Dysfunction diastolic, 429.9;
- With heart failure—see failure, heart;
- Due to cardiomyopathy—see Cardiomyopathy;
- Hypertension—see Hypertension, heart;
- Ventricular 429.9; or
- With congestive heart failure (see also Failure, heart, congestive), 428.

## Recovery Audit Finding: Peripheral/Cranial Nerve and Other Nervous System Procedures with MCC: MS-DRG 040

**Provider Types Affected:** Inpatient Hospitals

**Problem Description:** Recovery Auditors performed DRG validation on Medicare Severity Diagnosis-Related Group (MS-DRG) 040-Peripheral/Cranial Nerve and Other Nervous System Procedures with major complication or comorbidity (MCC).

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 for MS-DRG 040 (previously DRG 006, 007 and 008), principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG.

Here are two examples where MS-DRG 040 was coded incorrectly.

**Example 1:** An 85 year old female was found on the floor for an unknown amount of time. The patient was admitted with right-sided weakness, rhabdomyolysis, and altered mental status. The patient was diagnosed with acute cerebrovascular accident (CVA), acute renal failure, hypertension, sacral and heel ulcers.

**Past medical history:** hypertension.

**Physical examination:** Elderly female with confusion, weakness, and dysarthria. Pulse ox of 88% on room air, temperature 98.2, pulse

122, respiratory rate of 20, and blood pressure of 155/132. Right-sided facial droop, dysarthria, and right sided extremity weakness. CT scan revealed density and possible edema within anterior corpus possibly due to hemorrhagic infraction or tumor. The patient's BUN/Creatinine was 87/1.89 and was found to be in acute renal failure. She was started on intravenous fluids. Patient's carotids dopplers were negative. Echocardiogram revealed ejection fraction of 55%. An MRA of brain revealed decreased signal within the left middle cerebral artery territory.

The patient had wound debridement documented as debridement to fascia.

Excisional debridement of wound, infection, or burn (86.22) was coded as the principal procedure; however, the debridement was carried down to the fascia.

**Auditor Finding:** The patient's chart was originally assigned MS-DRG 040. However, after chart review for DRG validation, it was found that the patient did not have an excisional debridement (86.22), but did have debridement down to fascia (83.39). This resulted in MS-DRG change from 040 to 987 (non-extensive operating room (OR) procedure unrelated to principle diagnosis with MCC).

**Action:** Excision of lesion or tissue of other soft tissue (83.39) should be assigned instead of code 86.22. Overpayment is noted with DRG change from 040 to 987.

**Example 2:** An 82 year old male was seen at the cardiologist's office, and had an echocardiogram with an ejection fraction of 55%. When his carotids were examined, the patient went into asystole. He was given one ampule of atropine with resolution of the asystole. He was transferred to the hospital.

At the hospital, the patient presented with syncope. The patient has a past medical history, which includes Parkinson's disease, Alzheimer's disease, hypertension, and benign prostatic hypertrophy.

**Physical examination:** No acute exam findings. EKG normal sinus rhythm at 62 beats per minute, with left anterior hemi-block, and non-specific st-t wave changes. Patient had asystole with carotid massage and a dual chamber pacemaker was placed.

**Auditor finding:** Cardiac arrest (427.5) was coded as a secondary diagnosis, but is not supported by physician documentation and should be removed from the claim.

**Action:** Overpayment is noted with DRG change from 040 to 042-Peripheral/Cranial Nerve & Other Nervous System Procedures W/O CC/MCC.

## Guidance on How Providers Can Avoid These Problems:

Coders should always follow the ICD-9 Official Coding Guidelines for Coding and Reporting when selecting the principal diagnosis, as well as the appropriate Coding Clinics specific to the diagnosis and procedure codes to best describe the scenario.

1. Debridement of wounds (Coding Clinic 2<sup>nd</sup> Quarter 2005, page 3): If excisional debridement is coded, it must be carefully validated. When coding multiple layer debridement of the same site, the coder should assign a code only for the deepest layer of debridement. Also, note that a debridement carried out in conjunction with another procedure is often (but not always), included in the code for the procedure.
2. Code 427.5, Cardiac arrest (Coding Clinic 2<sup>nd</sup> Quarter 1988, page 8) (excludes that with pregnancy, anesthesia overdose or wrong substance given, and postoperative complications), may be assigned as principal diagnosis in the following instances:

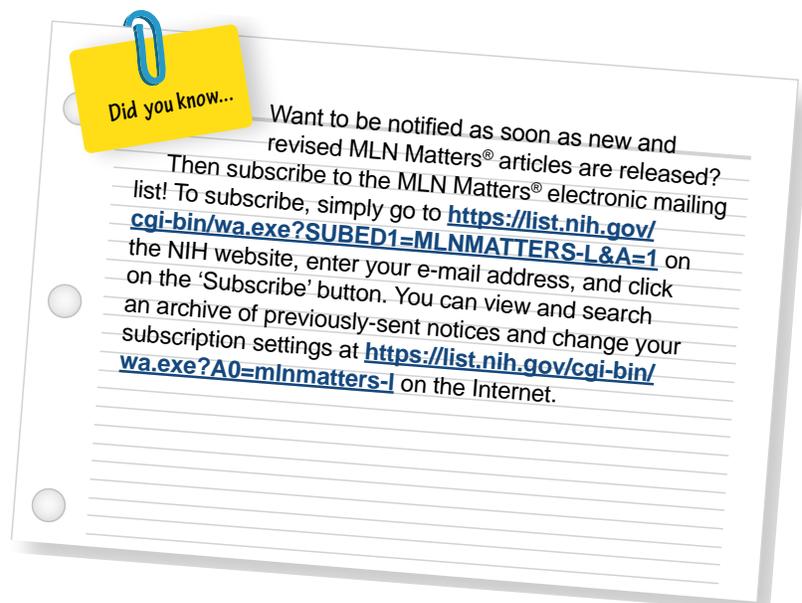
- ✓ If the patient arrives in the hospital's emergency service unit in a state of cardiac arrest, cannot be resuscitated or only briefly resuscitated, and is pronounced dead with the underlying cause of the cardiac arrest not established (cause unknown), code 427.5 is assigned as the diagnosis.
- ✓ If the patient arrives at the hospital in a state of cardiac arrest, is resuscitated, and is admitted as an inpatient but dies before the underlying cause of the cardiac arrest is established (cause unknown), code 427.5 is assigned as the principal diagnosis.

Code 427.5, Cardiac arrest, may be used as a secondary diagnosis in the following instances:

- ✓ The patient arrives in the hospital's emergency service unit in a state of cardiac arrest and is resuscitated (and admitted) with the condition prompting the cardiac arrest known, such as ventricular tachycardia or

trauma. The condition causing the cardiac arrest is sequenced first followed by code 427.5, Cardiac arrest.

- ✓ When cardiac arrest occurs during the course of hospitalization and the patient is resuscitated, code 427.5 may be used as a secondary code, except as outlined in the exclusion note under category 427.
- ✓ When the physician records cardiac arrest to indicate an inpatient death, do not assign code 427.5 when the underlying cause or contributing cause of death is known since the Uniform Hospital Discharge Data Set (UHDDS) has a separate item for reporting deaths occurring during an inpatient stay.



## Special Edition (SE) Article: Coding Vulnerabilities for Inpatient Hospitals

### SE1121 – Recovery Audit National Program Diagnosis Related Group (DRG) Coding Vulnerabilities for Inpatient Hospitals

#### Provider Types Affected:

This article is for all Inpatient Hospital providers that submit Fee-For-Service claims to Medicare Fiscal Intermediaries (FIs) or Part A/B Medicare Administrative Contractors (MACs).

#### Background:

Section 302 of the Tax Relief and Health Care Act of 2006 made the Recovery Audit Program permanent and required the Secretary to expand the program to all 50 states by no later than 2010. Each Recovery Auditor is responsible for identifying overpayment and underpayments in approximately ¼ of the country. The Recovery Audit Program jurisdictions match the Durable Medical Equipment (DME MAC) jurisdictions. More information about the Recovery Audit Program can be found at [http://www.cms.gov/RAC/01\\_Overview.asp](http://www.cms.gov/RAC/01_Overview.asp) on the CMS website.

#### Issues/Vulnerabilities:

Recovery Auditors have identified coding errors while performing DRG Validation review. One of CMS' strategies to reduce the error rate of claims is to correct vulnerabilities identified by the Recovery Auditors and other Medicare contractors. DRG Validation review focuses on the hospital's selection of principal and secondary diagnoses and procedures on a claim. MLN Matters® Special Edition Article #SE1121 provides guidance to inpatient hospitals on avoiding these vulnerabilities and can be found at <http://www.cms.gov/MLN MattersArticles/downloads/SE1121.pdf> on the CMS website.





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