

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 2, Issue 3 - April 2012**

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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.

Recovery Auditors are required to use clinicians, such as registered nurses or therapists for coverage/medical necessity determinations, and certified coders for coding determinations. Auditors are not authorized to go outside of their scope of practice. Some reviews may require the skills of both a clinician and a coder.

CMS issues the “Medicare Quarterly Provider Compliance Newsletter,” a Medicare Learning Network® (MLN) educational product, to help providers understand the major findings identified by Medicare Administrative Contractors (MACs), Recovery Auditors, Program Safeguard Contractors, Zone Program Integrity Contractors, the Comprehensive Error Rate Testing (CERT) review contractor and other governmental organizations, such as the Office of Inspector General. This is the third issue in the second year of the newsletter.

This issue includes six items identified by Recovery Auditors and two items identified by the CERT review contractor. This issue 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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MedQtrlyCompNL\\_Archive.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MedQtrlyCompNL_Archive.pdf) on the CMS website.

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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MedQtrlyCompNL\\_Index.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MedQtrlyCompNL_Index.pdf) on the CMS website.

# Comprehensive Error Rate Testing (CERT) Finding: 3-Day Qualifying Hospital Stay for Skilled Nursing Facility Stays

**Provider Types Affected:** Inpatient Hospital, Skilled Nursing Facility (SNF)

**Problem Description:** Medicare's Comprehensive Error Rate Testing (CERT) review contractor randomly selects claims processed by the Medicare program's claims processing contractors in order to establish a national improper payment rate. CERT also has undertaken a special study of inpatient hospital claims, targeted at various diagnosis-related groups (DRGs) historically found to be problematic. Reviews of these claims found a significant number of inpatient admissions with a length of stay of 3 to 5 days that were found to be medically unnecessary. Many of these cases involved beneficiaries who were subsequently transferred to a skilled nursing facility (SNF).

Some of these patients may have been admitted solely to satisfy the requirement for a minimum of 3 days as an inpatient in order to qualify for a SNF stay. Admitting an individual as an inpatient to avoid that person's potential financial responsibility for a SNF stay does not comply with Medicare rules and regulations. This could also lead to further enforcement actions. SNFs must also ensure that beneficiaries received in transfer from a hospital are truly eligible for such care.

**Example:** Mr. Jones went to the Emergency Department (ED) of his local hospital because he had been feeling weak and dizzy since he developed flu symptoms two days earlier. He was evaluated in the ED and found to have a viral illness, associated with mild dehydration. Treatment was begun with intravenous fluids and

acetaminophen for a mild fever; otherwise, he was given his usual oral medications that he takes at home on a daily basis. It was expected that his treatment would be completed within 12-24 hours. However, Mr. Jones's physician chose to admit him as an inpatient. Over the next 3-4 days, it became clear that Mr. Jones was no longer able care for himself in an adequate manner at home. Due to weakness and debility, he was subsequently transferred to a SNF.

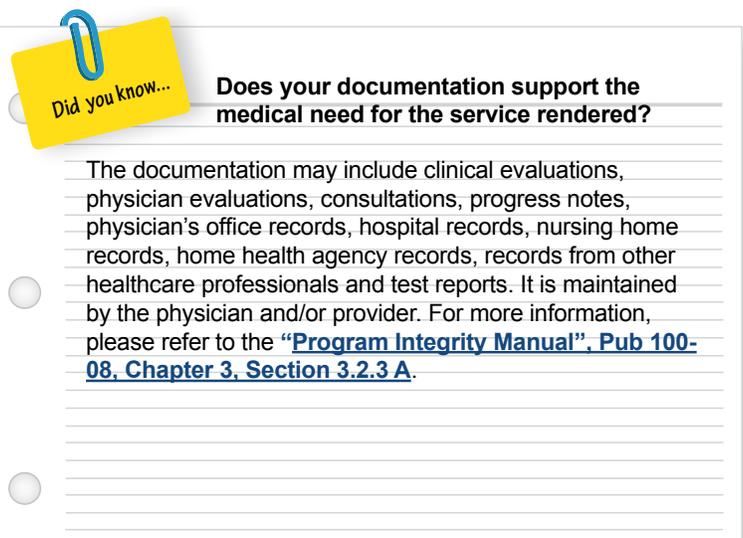
**Finding:** This example is problematic because Mr. Jones's admission as an inpatient in the hospital was not medically necessary. After evaluation in the ED, he was quite stable, in need only of some IV fluids, and discharge planning for placement in an alternative living situation, such as a nursing home or assisted living facility. Such treatment would have been more appropriately furnished

as outpatient observation services. Even if he was in need of skilled care, without a medically necessary 3-day inpatient hospital stay, Medicare cannot pay for SNF care.

It is important for hospitals to ensure that beneficiaries are admitted as inpatients only when they are truly in need of acute inpatient services. The Social Security Act requires that services furnished to Medicare beneficiaries are provided as economically as possible. Under the current Medicare statute, these claims must be denied in full.

## Guidance on How Providers Can Avoid These Problems:

In order to qualify for SNF services, a beneficiary must have been an inpatient of a hospital for a medically-necessary stay of at least 3 consecutive calendar days. The 3 consecutive calendar day stay requirement can be met by stays totaling 3 consecutive days in one or more hospitals. In determining



**Did you know...**

**Does your documentation support the medical need for the service rendered?**

- The documentation may include clinical evaluations, physician evaluations, consultations, progress notes, physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. It is maintained by the physician and/or provider. For more information, please refer to the "[Program Integrity Manual](#)", [Pub 100-08, Chapter 3, Section 3.2.3 A](#).
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whether the requirement has been met, the day of admission, but not the day of discharge, is counted as a hospital inpatient day. A patient is not an inpatient of a hospital until a physician (or other appropriate practitioner) has written an order for inpatient admission. Time spent receiving emergency department or observation services, or other outpatient services, does not count toward the three-day qualifying inpatient hospital stay.

The “Medicare Benefit Policy Manual,” Chapter 8, Coverage of Extended Care (SNF) Services Under Hospital Insurance, outlines Medicare’s policies and reimbursement rules. The manual is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf> on the CMS website.

The “Medicare Benefit Policy Manual,” Chapter 6, Hospital Services Covered Under Part B, section 20.6, Outpatient Observation Services, defines which outpatient services are eligible under Medicare

Part B. The manual is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf> on the CMS website.

“The Code of Federal Regulations 42 PART 409.30,” which is available at [http://www.ssa.gov/OP\\_Home/ssact/title11/1156.htm](http://www.ssa.gov/OP_Home/ssact/title11/1156.htm) states:

It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care facility, organization, or agency) who provides health care services for

which payment may be made (in whole or in part) under this act, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this act:

1. Will be provided economically and only when, and to the extent, medically necessary;
2. Will be of a quality which meets professionally recognized standards of health care; and
3. Will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

#### Resources:

Information about SNF consolidated billing (CB) is available at <http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html?redirect=/SNFConsolidatedBilling/> on the CMS website.

For information about the requirement for SNF and Swing Bed (SB) providers to report a prior qualifying hospital stay on all covered inpatient SNF and SB claims, please review Transmittal 1618 of the “Medicare Claims Processing Manual” at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1618CP.pdf> on the CMS website.

The “SNF Spell of Illness Quick Reference Chart” is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SNFSpellIllnesschart.pdf> on the CMS website.



## Comprehensive Error Rate Testing (CERT) Finding: Inpatient Hospital Consultations

**Provider Types Affected:** Inpatient Hospitals

**Problem Description:** Effective January 2010, CMS eliminated the use of all consultation codes (except for telehealth consultation G-codes). Since then, the CERT review contractor found a significant increase in the improper payment rates for the three Evaluation and Management (E/M) codes that replaced the codes for inpatient hospital consultations.

Physicians are instructed to code patient evaluation and management visits with E/M codes that represent the location where the service occurred, and reflect the complexity of the visit performed. In the hospital setting, all physicians (and qualified non-physician practitioners where permitted) who perform an initial evaluation may bill the initial hospital care codes (99221 – 99223).

The selection of E/M codes is generally based on the provision of specific services, such as a detailed or comprehensive history, a detailed or comprehensive examination, and medical decision making of varying complexity. However, when counseling and/or coordination of care dominates more than 50% of the unit/floor time spent caring for the beneficiary, time is the key or controlling factor in selecting the level of service. Unit/floor time includes the time the physician is present on the patient's hospital unit and at the bedside rendering services for that patient. **This includes the time during which**

**the physician establishes and/or reviews the patient's chart, examines the patient, writes notes, and communicates with other professionals and the patient's family.**

The code selection is based on the total time of the face-to-face encounter and floor time, not just the counseling time. The medical record must be documented in sufficient detail to justify the selection of a specific code if time is the basis for that selection.

In an inpatient setting, the counseling and/or coordination of care must be provided at the bedside or on the patient's hospital floor or unit that is associated with an individual patient. Time spent counseling the patient or coordinating the patient's care after the physician has left the patient's floor or begun to care for another patient on the floor is not considered when selecting the level of service to be reported.

When time is used for the selection of the level of service, the duration of counseling or coordination of care provided face-to-face or on the floor may be estimated. However, that estimate, along with the total duration of the visit, must be recorded in the medical record.

**Example:** At 10:00 am, Dr. Jones went to the room of Ms. Dressler on the third floor of the hospital at the request of her primary physician due to her newly-discovered kidney

disease. He performed a history and physical examination, which required 20 minutes. Dr. Jones then spent approximately 30 minutes with Ms. Dressler and her daughter discussing the implications of his findings, which included dietary restrictions, suggested medications, and the potential progression of her condition. Thereafter, while still on the third floor, Dr. Jones spent another 20 minutes discussing his findings with Ms. Dressler's primary physician and arranging for a registered dietitian to see her.

**Finding:** Since the time Dr. Jones spent counseling Ms. Dressler and coordinating her care was greater than 50% of the entire encounter, his choice of E/M code is determined by the amount of time spent caring for her. It is important to choose the correct code when billing for services provided to Medicare beneficiaries. This ensures that physicians are appropriately reimbursed for their work and Medicare funds are accurately paid and processed in a timely manner.

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

- ✓ The key to correct coding is **LOCATION and COMPLEXITY!** See the Resources section below for specific information.

## Resources:

- Review the “Medicare Claims Processing Manual,” Chapter 12, Section 30.6, at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf> on the CMS website.
- Review MLN Matters® Article #MM7405 titled “Clarification of Evaluation and Management (E/M) Payment Policy,” at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7405.pdf> on the CMS website.
- Review MLN Matters® Special Edition Article #SE1010 titled “Questions and Answers on Reporting Physician Consultation Services,” at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1010.pdf> for guidance on reporting physician consultation services.
- Review MLN Matters® Article #MM6740 titled “Revisions to Consultation Services Payment Policy,” at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6740.pdf> on the CMS website.
- E/M documentation guidelines are available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html> on the CMS website.

The Medicare Learning Network® (MLN) publication titled “The Evaluation and Management Services Guide” is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval\\_mgmt\\_serv\\_guide-ICN006764.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf) on the CMS website.



Did you know...

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

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

## Recovery Audit Finding: Cholecystectomy–Incorrect Secondary Diagnosis

### Provider Types Affected: Inpatient Hospitals

**Problem Description:** The purpose of Medicare Severity - Diagnosis Related Group (MS-DRG) Validation is to determine that the principal diagnosis, procedures and all secondary diagnoses identified as Complications or Comorbidities (CCs) and Major Complications or Comorbidities (MCCs) are present, correctly sequenced, coded and clinically validated. When a patient is admitted to the hospital, the condition found to be chiefly responsible for causing the admission to the hospital and was established after study should be sequenced as the principal diagnosis. The other diagnoses identified should include all conditions present during the admission that impacted the stay. The Present on Admission (POA) indicator for all diagnoses reported must be coded correctly. For this finding, reviewers examined claims containing:

- ✓ MS-DRG 417 Laparoscopic Cholecystectomy without C.D.E. with MCC
- ✓ MS-DRG 418 Laparoscopic cholecystectomy without C.D.E. with CC
- ✓ MS-DRG 419 Laparoscopic cholecystectomy without C.D.E. without CC/MCC

**Example:** A 67-year-old male was admitted through the Emergency Department (ED) with precordial and epigastric pain. After additional evaluation it was determined that the patient's pain was due to acute cholecystitis with cholelithiasis. Surgery was consulted, and the patient underwent laparoscopic

cholecystectomy for acute cholecystitis and cholelithiasis. The progress note on postoperative day 0 stated that the patient had some minimal bleeding, and the patient was hemodynamically stable. Within the hospital course of the discharge summary it was noted that the only complication was some minimal bleeding from the Jackson-Pratt (JP) drain, and the patient's blood count remained stable. The bleeding terminated, and the patient's lowest hemoglobin, 10.5, was on the day of discharge, and his hematocrit on discharge was 31. The patient's discharge summary documented a final diagnosis of cholelithiasis with acute cholecystitis, posthemorrhagic anemia, and acute coronary syndrome was ruled out. The patient was discharged to home.

**Finding:** Diagnosis was not supported by medical documentation.

A secondary diagnosis was coded that was not supported by documentation. In this case, ICD-9-CM Diagnosis code 285.1 (Acute Posthemorrhagic Anemia (anemia due to acute blood loss)) was changed to ICD-9-CM Diagnosis code 280.0 (Iron Deficiency Anemia Secondary to Blood Loss (chronic)) for posthemorrhagic anemia, unspecified. Per the ICD-9-CM alphabetic index, anemia, posthemorrhagic codes to 280.0 without further specification of the acuity. The documentation contained in the medical record did not document the term "acute" in describing the posthemorrhagic anemia. This change in coding

resulted in an MS-DRG change from 418 - Laparoscopic cholecystectomy without C.D.E. with CC to MS-DRG 419 - Laparoscopic cholecystectomy without C.D.E. without CC/MCC.

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

When coding for an inpatient hospital stay:

- ✓ The condition chiefly responsible for a patient's admission to the hospital should be sequenced as the principal diagnosis. Code only those conditions documented by the physician. Other identified diagnoses should include all conditions present during the admission that affect the hospital stay. The Present on Admission (POA) indicator for all diagnoses reported (both principal and secondary) must be coded correctly.
- ✓ Review the "ICD-9-CM Coding Manual" (for dates of service on the claim) and the "ICD-9-CM Addendums and Coding Clinics" about coding guidelines on sequencing and selection of principal diagnosis. Relevant Coding Clinics for Example include 2007 1st quarter; 1993 4th quarter; and 1992 2nd quarter.
- ✓ Follow coding guidelines and Uniform Hospital Discharge Data Set (UHDDS) definitions of when to code secondary diagnoses and chronic conditions. Do not code diagnoses not documented in the record.

**Resources:**

- The MLN fact sheet titled “Present on Admission (POA) Indicator Reporting by Acute Inpatient Prospective Payment System (IPPS) Hospitals” clarifies how to apply POA indicators to diagnosis codes for certain healthcare claims. This fact sheet is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/wPOAFactSheet.pdf> on the CMS website.



**Did you know...** Visit the Medicare Learning Network® (MLN) Provider Compliance web page at [http://www.cms.gov/MLNProducts/45\\_ProviderCompliance.asp](http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp) for the latest educational products designed to help Medicare Fee-For-Service providers understand – and avoid – common billing errors and other improper activities.

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## Recovery Audit Finding: Kidney and Urinary Tract Disorders—Incorrect Principal Diagnosis

**Provider Types Affected:** Inpatient Hospitals

**Problem Description:** Medicare Severity - Diagnosis Related Group (MS-DRG) validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded on the hospital claim, matches both the attending physician description and the information contained in the medical record. 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 include all conditions present during the admission that impact the stay. The Present on Admission (POA) indicator for all diagnoses reported must be coded correctly. Among the MS-DRGs involved in this study were:

- ✓ MS-DRG 684 Renal Failure w/o CC/MCC
- ✓ MS-DRG 690 Kidney and Urinary Tract Infections without MCC
- ✓ MS-DRG 700 Other Kidney and Urinary Tract Diagnoses w/o CC/MCC

**Example 1:** A 92-year-old female patient presented with generalized weakness, and she stated that her Foley catheter was changed recently, but she did not remember when. The patient also stated that she has had other Urinary Tract Infections (UTIs). She has a history

of hypertension and neurogenic bladder with a chronic indwelling Foley catheter. The patient also has early dementia and lives in a Skilled Nursing Facility (SNF).

**Finding:** In this case, MS-DRG 700 (Other Kidney and Urinary Tract Diagnoses without CC/MCC) was billed using the principal diagnosis code 996.64 (Infection/inflammatory reaction due to indwelling urinary catheter). Review of the medical record revealed the documentation does not support that the UTI was due to the urinary catheter. In accordance with coding guidelines, the physician must link the infection to the device. The physician documented that the patient has a UTI with chronic indwelling Foley catheter for neurogenic bladder. The term ‘with’ does not clearly state a cause and effect relationship, or indicate the UTI was due to the urinary catheter for coding purposes. There was no evidence in the medical record to determine if the physician had been queried as to the cause of the UTI. Therefore, diagnosis code 996.64 (Infection/Inflammatory Reaction Due to Indwelling Urinary Catheter) is being omitted and diagnosis code 599.0 (Urinary Tract Infection) is being sequenced as the principal diagnosis. This change in principal diagnosis results in assignment to MS-DRG 690 (Kidney and Urinary Tract Infections without MCC).

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

To prevent payment denial, hospitals should ensure that:

- ✓ 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). Other identified diagnoses should include all conditions present during the admission that impact the hospital stay. In addition, the POA indicator for all diagnoses reported (both principal and secondary) must be coded correctly.
- ✓ All medical documentation entries are 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 matches both the attending physician’s description/diagnosis and the information contained in the beneficiary’s medical record. Should there be a physician query for additional clarification

of medical record documentation, the results of this query should be included in the medical record to support the code selection.

#### Resources:

- The MLN fact sheet titled “Present on Admission (POA) Indicator Reporting by Acute Inpatient Prospective Payment System (IPPS) Hospitals” clarifies how to apply POA indicators to diagnosis codes for certain healthcare claims. This fact sheet is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/wPOAFactSheet.pdf> on the CMS website.
- The OIG Report OEI-01-98-00420 titled “Subject Monitoring the Accuracy of Hospital Coding” (OEI-01-98-00420) is available at <http://oig.hhs.gov/oei/reports/oei-01-98-00420.pdf> on the Internet.
- The “Medicare Program Integrity Manual,” Chapter 6, Intermediary MR Guidelines for Specific Services, Section 6.5.3, DRG Validation Review, discusses the DRG validation process and some coding requirements. The manual can be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c06.pdf> on the CMS website.
- The “ICD-9-CM Official Guidelines for Coding and Reporting,” Section II – Selection of Principal Diagnosis, is available at [http://www.cdc.gov/nchs/data/icd9/icd9cm\\_guidelines\\_2011.pdf](http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf) on the Internet.

- Review the “ICD-9-CM Coding Manual” and “ICD-9-CM Addendums and Coding Clinics” for coding guidelines on sequencing and selection of principal diagnosis. For Example 2, relevant coding clinics include the AHA Coding Clinic™, Third Quarter 2009, page 10, Indwelling Urinary Catheter and Urinary Tract Infection.
- Follow coding guidelines and Uniform Hospital Discharge Data Set (UHDDS) definitions for when to code secondary diagnosis and chronic conditions. Do not code diagnoses that are not documented in the record.



Did you know...

A Medicare overpayment is a payment made to a physician or supplier that exceeds amounts due and payable under Medicare statute and regulations. Once the overpayment is determined, the amount becomes a debt owed by the debtor to the Federal government. Federal law requires CMS to seek the recovery of all identified overpayments. For more information about the Medicare overpayment collection process, please download the Medicare Learning Network® fact sheet titled “The

Medicare Overpayment Collection Process” from the MLN Publications web page at <http://www.cms.gov/MLNProducts/MPUB/list.asp>.

## Recovery Audit Finding: Transient Ischemic Attack - Services Rendered in a Medically Unnecessary Setting

**Provider Types Affected:** Inpatient Hospitals

**Problem Description:** Medicare Recovery Auditors performed a 3-year demonstration review of inpatient hospital claims for services that may have been provided in an improper setting. These are situations where the beneficiary needed care but did not need to be admitted to the hospital to receive that care. The Recovery Auditor Demonstration Project Report for this demonstration is available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/index.html> on the CMS website.

The following two examples highlight medical necessity reviews that were performed to substantiate the need for inpatient admission versus observational level of care for patients with diagnosis of Transient Ischemic Attacks (TIAs) (MS-DRG 069 Transient Ischemia). In the examples, both patients had TIA symptoms that resolved spontaneously, without intervention. The patient's initial Computed Tomography (CT) scans were also negative for acute intracranial pathology. The patients were placed into the hospital for neurological checks, further diagnostic testing, and cardiac monitoring. Both these patients were discharged the following day.

**Example 1:** A 95-year-old female presented to the Emergency Department (ED) with a complaint of left sided arm numbness and facial numbness that lasted for several hours. The symptoms had resolved by the time the

patient arrived at the emergency department. The patient had a past medical history of multiple TIAs, dementia, hypertension, chronic anemia, anxiety, dyslipidemia, diastolic dysfunction, and Gastroesophageal Reflux Disease (GERD).

The patient's blood pressure was 197/86, pulse 71, temperature 96.9, and pulse ox of 93%. Her chest x-ray showed no acute disease, and the CT scan of the head showed no acute cranial abnormalities. Her cardiac enzymes were negative, and chest and lung exams were unremarkable. A neurologic exam revealed no focal deficits and muscle strength 5/5 in all extremities. The patient's blood pressure decreased to 121/65 after receiving Dilaudid 0.5 mg IV antihypertensive medication, and the patient's first recorded blood pressure upon arrival to the floor was 147/65. The patient was restarted on lisinopril 10mg daily, as well as her prior home medications. The patient was admitted on September 17, 2010, and she was discharged on September 18, 2010, with a diagnosis of left sided arm numbness, likely secondary to TIA.

**Example 2:** A 49-year-old male patient with a history of Cerebrovascular Accidents (CVAs) presented to the ED after having a 'funny feeling on his left side' and slurred speech both of which resolved prior to his arrival at the ED. The patient stated that his symptoms lasted

for 15 min, and the admission examination documented the patient was in no distress, lungs were clear, heart rate regular, and he was neurologically intact. His Electrocardiogram (EKG) read as no acute changes, and radiology showed no acute processes. The patient received IV antihypertensive medication in the ED for elevated blood pressure but resumed his regular antihypertensive medications on the floor. Documentation questioned the patient's compliance with his regular medications. The patient's CT scan showed no acute cranial abnormalities. The patient's blood sugar level in the emergency room was initially HIGH, and which was treated in the ED. He was placed in the hospital, and his high blood sugar was treated with NPH insulin. However, the patient was non-compliant with his diabetic diet, and he was found to be eating fast food brought in by his family members. The patient was admitted on December 8, 2009, and was discharged on December 9, 2009.

**Finding:** The Recovery Audit determined that the requirements for inpatient status, as outlined in Medicare regulatory documents, were not met. The "Medicare Program Integrity Manual," Chapter 6, Intermediary MR Guidelines for Specific Services, Section 6.5.2.A, Determining Medical Necessity and Appropriateness of Admission, states that:

“Inpatient care rather than outpatient care is required only if the beneficiary’s medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting.”

In order to determine medical necessity and the appropriateness of admission, the manual continues to instruct that:

“The reviewer shall consider, in his/her review of the medical record, any pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary. Factors that may result in an inconvenience to a beneficiary or family do not, by themselves, justify inpatient admission. When such factors affect the beneficiary’s health, consider them in determining whether inpatient hospitalization was appropriate. Inpatient care rather than outpatient care is required only if the beneficiary’s medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. Without accompanying medical conditions, factors that would only cause the beneficiary inconvenience in terms of time and money needed to care for the beneficiary at home or for travel to a physician’s office, or that may cause the beneficiary to worry, do not justify a continued hospital stay.”

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

By definition, A transient ischemic attack (TIA) is an acute episode of temporary neurologic dysfunction resulting from focal cerebral ischemia not associated with permanent cerebral infarction. The clinical

symptoms of TIA typically last less than an hour, but prolonged episodes can occur. While the classical definition of TIA included symptoms lasting as long as 24 hours, advances in neuroimaging have suggested that many such cases represent minor strokes with resolved symptoms rather than true TIAs. Physicians may document TIA/CVA in the medical record if the clinical evidence is suggestive rather than definitive. The physician should be queried to determine if a CVA was suspected, possible, or probable. The results of this physician query should be documented within the medical record.

The “Medicare Benefit Policy Manual,” Chapter 1, Section 10, provides information about Medicare covered inpatient hospital services. Section 10 states that “patients covered under hospital insurance are entitled to have payment made on their behalf for inpatient hospital services.” Section 10 continues to state:

“An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.”

“The physician or other practitioner responsible for a patient’s care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark, i.e., they

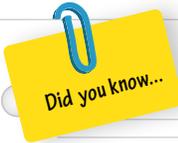
should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient’s medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital’s by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures at the time when and at the location where the patient presents.”

The “Medicare Program Integrity Manual,” Chapter 6, Intermediary MR Guidelines for Specific Services, Section 6.5.2.A, Determining Medical Necessity and Appropriateness of Admission, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c06.pdf> on the CMS website.

**Resources:**

- The “Medicare Benefit Policy Manual,” Chapter 1, Inpatient Hospital Services Covered Under Part A, Section 10, Covered Inpatient Hospital Services Covered Under Part A, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf> on the CMS website.
- MLN Matters® Article #SE1121 titled “Recovery Audit Program Diagnosis Related Group (DRG) Coding Vulnerabilities for Inpatient Hospitals” is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1121.pdf> on the CMS website and
- The “Medicare Claims Processing Manual,” Chapter 12, Physicians/Nonphysician Practitioners, Section 30.6.8, Payment for Hospital Observation Services and Observation or Inpatient Care Services (Including Admission and Discharge Services), is available at <http://www.cms.gov/manuals/downloads/clm104c12.pdf> on the CMS website.



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## Recovery Audit Finding: Craniotomy and Endovascular Intracranial Procedures

### Provider Types Affected: Inpatient Hospitals

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

- ✓ MS-DRG 025 Craniotomy & endovascular intracranial procedures with Major Complication/Comorbidity (MCC),
- ✓ MS-DRG 026 Craniotomy & endovascular intracranial procedures with Complication/Comorbidity (CC), and
- ✓ MS-DRG 027 Craniotomy & endovascular intracranial procedures without CC/MCC.

**Examples of Coding Errors:** Below are two examples of coding errors:

**Example 1:** The patient is a 93-year-old male admitted with cerebrovascular accident on October 15, 2008. The provider assigned secondary diagnosis code 348.30 (Encephalopathy). There is no documentation within the medical record, that the patient has encephalopathy.

**Finding:** The removal of code 348.30 (Encephalopathy) changed the MS DRG from 25 Craniotomy & Endovascular Intracranial

procedures with MCC to MS DRG 26 Craniotomy & Endovascular Intracranial procedure with CC. This review resulted in an overpayment determination.

**Example 2:** An 82-year-old male patient was admitted to the hospital on February 9, 2010, for a meningioma. The history and physical documented "brain mass with edema and 20 mm. midline shift". Code 348.5 (Other Conditions of Brain; Cerebral Edema) to capture this documented edema was not included in the Medicare billing and has been added.

**Finding:** The billed MS-DRG of 27 Craniotomy and Endovascular Intracranial Procedures without CC/MCC will change to MS-DRG 025 Craniotomy and Endovascular Intracranial Procedures with MCC with the addition of code 348.5. This review resulted in an underpayment determination.

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

- ✓ Coders should conduct a thorough review of physician documentation before assigning and reporting codes.
- ✓ In example 1, the medical record does not support the diagnosis code 348.30 Encephalopathy based on lack of physician documentation of the patient having encephalopathy.

- ✓ In example 2, the history and physical documented brain mass with edema and 20 mm midline shift, but the code for edema was not included.
- ✓ A thorough review of physician documentation must be done before assigning and reporting ICD-9-CM codes.
- ✓ Use of ICD-9-CM Coding Manual can provide further guidance.



## Recovery Audit Finding: Small and Large Bowel Procedures

### Provider Types Affected: Inpatient Hospitals

**Problem Description:** Medicare Severity Diagnosis Related Group (MS-DRG) Validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, match both the attending physician description and the information contained in the beneficiary's medical record. Using the Comprehensive Error Rate Testing (CERT) program and the Hospital Payment Monitoring Program (HPMP), reviewers validated for the following:

- MS-DRG 329 Major small and large bowel procedures with Major Complication/Comorbidity (MCC),
- MS-DRG 330 Major small and large bowel procedures with Complication/ Comorbidity (CC),
- MS-DRG 331 Major small and large bowel procedures without CC/MCC,
- Principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the MS-DRG.

**Examples of Coding Errors:** Here are two examples of errors in coding:

**Example 1:** A 67-year-old female was admitted to the facility with diverticulitis on November 8, 2007. The patient had a history of recurrent episodes of diverticulitis in the last year. The patient was admitted to the facility for the procedure of laparoscopic sigmoid colectomy,

partial, with anastomosis, with coloproctostomy. No complications were noted during the surgery and postoperatively.

The provider assigned the secondary diagnosis code of 569.5 (Other Disorder of Intestine; Abscess of Intestine). The physician documentation did not indicate that the patient had an abscess of the intestine in the medical record including the discharge summary, history and physical, and progress notes. Therefore, with this lack of documentation for an abscess of the intestine, the secondary diagnosis code of 569.5 (Other Disorder of Intestine; Abscess of Intestine) was deleted.

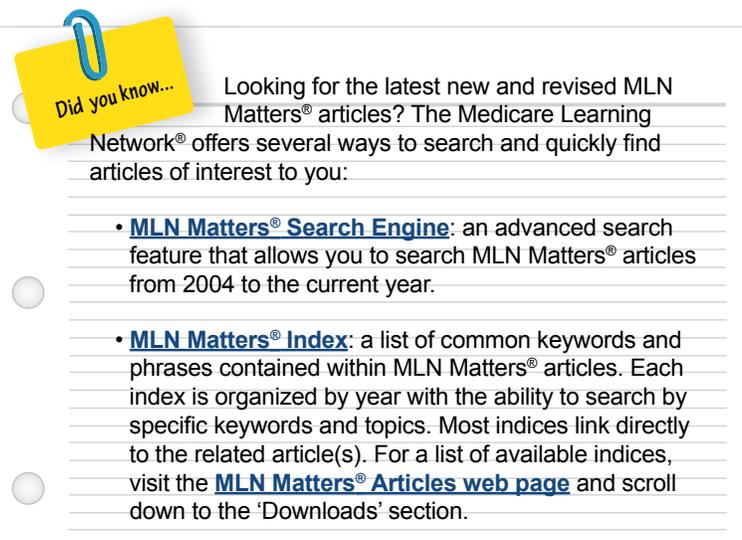
**Finding:** The deletion of code 569.5 (Other Disorder of Intestine; Abscess of Intestine) changed the MS-DRG from 330 (Major Small and Large Bowel Procedure with CC) to MS-DRG 331 (Major Small and Large Bowel Procedure without CC/MCC).

**Example 2:** This patient is a 73-year-old female who was found to have invasive adenocarcinoma of the ascending colon by colonoscopy. She had a right colectomy with primary anastomosis during this admission.

A Body Mass Index (BMI) of greater than 40 (V85.4) was originally coded, which was the only CC for this case, along with the physician documented diagnosis of obesity. There was no supporting documentation of the patient's BMI greater than 40.

The Nutritional Assessment, done on February 14, 2008, was reviewed. It was found that the patient's height and weight was recorded, but the actual BMI was not documented by the dietician.

The Official ICD-9-CM Coding Guidelines provide the following guideline for documentation for BMI and Pressure Ulcer Stages:



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I.B. 16. For the Body Mass Index (BMI) and pressure ulcer stage codes, code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI and nurses often documents the pressure ulcer stages). However, the associated diagnosis (such as overweight, obesity, or pressure ulcer) must be documented by the patient's provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient's attending provider should be queried for clarification.

The BMI and pressure ulcer stage codes should only be reported as secondary diagnoses. As with all other secondary diagnosis codes, the BMI and pressure ulcer stage codes should only be assigned when they meet the definition of a reportable additional diagnosis (see Section III, Reporting Additional Diagnoses).

Without documentation within the medical record of the BMI by a clinician, it should not be coded or reported. If a physician query was made to obtain additional information, such as the BMI, this information must be included within the medical record documentation in order for it to be the basis of a code assignment.

**Finding:** This changed the MS-DRG from 330 (Major Small and Large Bowel Procedure with CC) to MS-DRG 331 (Major Small and Large Bowel Procedure without CC/MCC).

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

- ✓ Check for the presence of Major Complications and Comorbidities (MCC) or the presence of Complications and Comorbidities (CC).
- ✓ Coders should not code findings from pathology reports on inpatient records without confirmation of the diagnosis from the attending physician.
- ✓ Coders may not calculate the BMI from the patient's height and weight. If clinically significant, you may query the physician. The results of this physician query must be included within the medical record documentation.
- ✓ Review Coding Clinic 2nd Q 2002, page 18; Coding Clinic 1st Q 2004, pages 20-21; and Coding Clinic 4th Q 2008, page 191. ICD-9-CM Official Coding Guidelines – I.B. 16.



## Recovery Audit Finding: Spinal Fusion

**Provider Types Affected:** Inpatient Hospitals

**Problem Description:** The purpose of Medicare Severity Diagnosis Related Group (MS-DRG) validation is to determine that the principal diagnosis, procedures and all secondary diagnoses identified as Complication/Comorbidity (CC) and Major Complication/Comorbidity (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 diagnoses identified should represent all CC/MCC present during the admission that affects the stay. The Present on Admission (POA) indicator for all diagnoses reported must be coded correctly.

For this issue, reviewers validated for the following:

- ✓ MS-DRG 453 Combined Anterior/Posterior Spinal Fusion with MCC,
- ✓ MS-DRG 454 Combined Anterior/Posterior Spinal Fusion with CC,
- ✓ MS-DRG 455 Combined Anterior/Posterior Spinal Fusion without CC/MCC,
- ✓ MS-DRG 456 Spinal Fusions Except Cervical with Spinal Curvature, Malignancy or 9+ Fusions with MCC,
- ✓ MS-DRG 457 Spinal Fusions Except Cervical with Spinal Curvature, Malignancy or 9+ Fusions with CC,

- ✓ MS-DRG 458 Spinal Fusions Except Cervical with Spinal Curvature, Malignancy or 9+ Fusions without CC/MCC,
- ✓ MS-DRG 459 Spinal Fusion Except Cervical with MCC,
- ✓ MS-DRG 460 Spinal Fusion Except Cervical without MCC, and
- ✓ Principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG.

**Examples of Coding Errors:** Below are two examples of coding errors:

**Example 1:** An 82-year-old female presents with a history of back pain and with a history and physical impression of spinal stenosis and scoliosis with surgical intervention planned. The patient had been followed in the clinic and was seen one month prior to her current admission. Office notes from that visit state the pain began approximately 5 months ago and the onset was spontaneous and gradual. The pain radiates into the left thigh. There was moderate improvement with therapies. Imaging studies were performed and Magnetic Resonance Imaging (MRI) showed stenosis at L2-3, L3-4, and L4-S1. There is disc space narrowing and a synovial cyst.

**Impression:** Spinal stenosis; asthma; aortic stenosis; acid reflux; polymyalgia rheumatica; neuropathy; history of renal cancer; hematuria; incontinence.

**Diagnoses:** Degenerative lumbar/lumbosacral; displaced lumbar disc; postlaminectomy syndrome; radiculopathy; sciatica; scoliosis, and spondylosis lumbosacral.

On the day of admission, the patient underwent a complex revision bilateral hemilaminectomy L1, L2, L3, L4, L5, S1 with removal of synovial cyst with neurolysis with foramenotomies with posterior lateral fusion with allo autograft with bone marrow aspiration. Decompression laminectomy L1 to S1.

The patient tolerated the procedure well and was seen by physical and occupational therapies on a daily basis. She was discharged home.

**Pre/Postoperative Diagnoses:** Spinal stenosis with postlaminectomy syndrome with scoliosis, degenerative disc disease L1 to S1.

**Finding: The hospital reported scoliosis as the principal diagnosis.** The treatment was for the spinal stenosis and therefore the principal diagnosis was changed to 724.02 spinal stenosis and scoliosis was moved to a secondary diagnosis.

This coding change caused an MS DRG change from 458 spinal fusion except cervical with spinal curvature/malignancy/infection or 9+ fusion without CC/MCC to MS-DRG 460 spinal fusion except cervical without MCC.

**Example 2:** A 73-year-old male with spinal stenosis and degenerative scoliosis was admitted for surgical intervention of his extensive degenerative joint disease.

Indications for a laminectomy were a progressively increasing low back and lower extremity neurogenic claudicatory pain with a lack of response to conservative therapy. Patient was previously scheduled for this procedure one month ago but was found to have a small abscess on his skin at the site of the surgery and therefore the surgery was cancelled and patient presents now for surgery.

**Impression:** spinal stenosis, spondylosis, diffuse disc bulge L3 - revision L1-L3 decompression, fusion; hypertension; dyslipidemia; history of supraventricular tachycardia; parastheses, left greater than right lower extremities. Patient underwent a revision laminectomy with fusion and tolerated the procedure well.

**Operation:** 1) Revision L2-3 laminectomy decompression of canal and lateral recess as well as neurolysis; 2) L1-2 laminectomy with decompression of canal and lateral recess; 3) L1-2, L2-3 spinal fusion; 4) harvesting of left iliac crest. The body of the operative report does not document the use of any spinal instrumentation. The patient tolerated the procedure well and progressed well with physical therapy and was discharged home in stable condition.

**Final diagnosis:** 1) stenosis; 2) degenerative scoliosis; 3) postlaminectomy.

**Finding:** The principal diagnosis was changed from 737.39 scoliosis to 724.02 spinal stenosis. Scoliosis was designated as a secondary diagnosis. The reason for the admission as well as the definitive surgical treatment was for the spinal stenosis, not the scoliosis.

This change caused an MS-DRG change from MS-DRG 457 spinal fusion, except cervical with spinal curvature, malignancy, infection or 9+ fusions, with CC to MS-DRG 460 spinal fusion, except cervical, without MCC.

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

Providers must follow official coding guidelines on sequencing of principal diagnosis.

- ✓ In Example 1, there was improper sequencing of the principal diagnosis. In this case, the treatment was for the spinal stenosis and this is the reason for the patient's admission.
- ✓ In Example 2, there was improper sequencing of the principal diagnosis based on official coding guidelines. In this case, the surgical intervention was for the treatment of the spinal stenosis.





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