



RAC Top Findings through September 30, 2007: Claims Paid Between Oct. 2001-Sept. 2006

Problem Area	Type of Problem	Guidelines	State	Overpayment
Inpatient Hospital Claims				
Excisional Debridement (Procedure codes 86.22, 86.28)	Incorrect Coding: Procedure code on claim did not match procedure described in medical record. Provider did not code the claim consistent with the Coding Clinic definition of excisional debridement.	The following Coding Clinics provide instructions regarding excisional debridements: 3Q '91, 1Q '99, 2Q '00, 2Q '04, 4Q '06.	New York	\$40.4 million
			Florida	\$2.3 million
			California	\$6.2 million
Heart Failure and Shock (DRG 127)	Medical Necessity: It was not medically necessary for patients to receive services in an inpatient setting. Patients could have been treated in an outpatient setting.	Refer to Interqual guidelines for inpatient acuity.	New York	\$8.6 million
			Florida	\$9.7 million
			California	\$2.0 million
Respiratory Failure (DRG 475; various diagnosis codes)	Incorrect Coding: Principal diagnosis on claim did not match the principal diagnosis in the medical record. Provider did not code the claim consistent with the Coding Clinic guidance for respiratory failure.	The following Coding Clinics provide instruction regarding respiratory failure: 2Q '90, 4Q '90, 2Q '91, 3Q '91, 4Q '98, 1Q '03, 4Q '04, 1Q '05.	New York	\$12.4 million
			Florida	\$2.1 million
			California	\$5.7 million

<p>Operating Room Procedure Unrelated to Principal Diagnosis (DRG 468; various diagnosis codes)</p>	<p>Incorrect Coding: 1) Principal diagnosis on the claim did not match the principal diagnosis in the medical record. 2) Diagnosis sequencing was incorrect. The secondary diagnosis should have been coded as the primary diagnosis.</p>	<p>Federal Register: February 11, 1998 (Volume 63, Number 28) provides guidance on the proper coding of nondiagnostic preadmission services. Refer also to the American Hospital Association's definitions of Principal diagnosis and Principal Procedure, found in the ICD-9-CM Official Guidelines for Coding and Reporting.</p>	<p>New York Florida California</p>	<p>\$3.9 million \$1.9 million \$5.9 million</p>
<p>Inpatient Rehabilitation Facility (IRF) Claims</p>				
<p>IRF services for single joint replacements (HIPPS codes A0801-A0806)</p>	<p>Medical Necessity: Services could have been provided in a less acute setting. Provider admitted patients who did not meet CMS' medical necessity criteria for IRF care.</p>	<p>HCFA Ruling 85-2 lists the medical necessity criteria for services provided in an IRF. The ruling can be found at: http://www.cms.hhs.gov/Rulings/downloads/HCFAruling85-2.pdf.</p>	<p>California</p>	<p>\$31.6 million</p>
<p>Other IRF services (HIPPS codes AXXYY)</p>	<p>Medical Necessity: Services could have been provided in a less acute setting. Provider admitted patients who did not meet CMS' medical necessity criteria for IRF care.</p>	<p>HCFA Ruling 85-2 lists the medical necessity criteria for services provided in an IRF. The ruling can be found at: http://www.cms.hhs.gov/Rulings/downloads/HCFAruling85-2.pdf.</p>	<p>California</p>	<p>\$4.9 million</p>
<p>IRF services for Miscellaneous conditions (HIPPS codes A2001-A2004)</p>	<p>Medical Necessity: Services could have been provided in a less acute setting. Provider admitted patients who did not meet CMS' medical necessity criteria for IRF care.</p>	<p>HCFA Ruling 85-2 lists the medical necessity criteria for services provided in an IRF. The ruling can be found at: http://www.cms.hhs.gov/Rulings/downloads/HCFAruling85-2.pdf</p>	<p>California</p>	<p>\$2.6 million</p>

Outpatient Hospital Claims

<p>(Pegfilgrastim) Neulasta (HCPCS code J2505)</p>	<p>Incorrect Coding: Wrong number of units billed. Provider billed for 6 units of Neulasta when they only administered one unit of 6MG.</p>	<p>Transmittal 949 clarifies the billing for Neulasta. The transmittal can be found at: http://www.cms.hhs.gov/transmittals/downloads/R949CP.pdf.</p>	<p>New York</p>	<p>\$6.2 million</p>
<p>Speech Therapy (CPT codes 92506, 92507)</p>	<p>Incorrect Coding: Wrong number of units billed. Provider billed for each 15 minutes of therapy instead of billing for each session of therapy.</p>	<p>CMS Claims Processing Manual 100-4, Chapter 5, Section 20.2 clarifies billing for untimed codes. The section be found at: http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf.</p>	<p>New York California</p>	<p>\$2.6 million \$2.9 million</p>
<p>Blood Transfusion (CPT code 36430)</p>	<p>Incorrect Coding: Wrong number of units billed. Provider billed for each unit of blood instead of billing for one transfusion session.</p>	<p>CMS Claims Processing Manual 100-4, Chapter 4, Section 231.8 clarifies billing for blood transfusion services. This section can be found at: http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf.</p>	<p>New York California</p>	<p>\$2.7 million \$1.3 million</p>

Skilled Nursing Facility (SNF) Claims

<p>SNF Services without a Prior 3-Day Hospital Stay (various codes)</p>	<p>Other: Provider admitted patients to SNF without a prior 3 day hospital stay.</p>	<p>CMS Claims Processing Manual 100-4, Chapter 7, Section 10 clarifies admission guidelines to a SNF. This section can be found at: http://www.cms.hhs.gov/manuals/downloads/clm104c07.pdf</p>	<p>Florida</p>	<p>\$4.1 million</p>
<p>Physical and Occupational Therapy (various codes)</p>	<p>Medical Necessity: It was not medically necessary for patients to receive services by a skilled therapist. Services could have been provided by an aide.</p>	<p>CMS Benefit Policy Manual 100-2, Chapter 15, Section 220.2 outlines complete coverage criteria for outpatient therapy services. This section be found at: http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf</p>	<p>California</p>	<p>\$4.8 million</p>
<p>Speech Language Pathology Services (various codes)</p>	<p>Medical Necessity: Services were billed in excess of Medicare's "Medically Unbelievable Edits" limits.</p>	<p>CMS Claims Processing Manual 100-4, Chapter 5, Section 20.2 clarifies billing for untimed codes. The section be found at: http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf.</p>	<p>California</p>	<p>\$1.5 million</p>

Physician Claims

Vestibular Function (CPT codes 92541, 92542, 92545, 92546, 92547)	Medical Necessity: Provider billed for multiple units when only 1 unit per day is medically necessary.	NHIC LCD #05-02-01 clarifies billing for vestibular function tests in California.	Florida	\$1.7 million
		See also Federal Register November 15, 2004 (Volume 69, Number 219) for guidelines on vestibular function testing.	California	\$6.9 million
Multiple Surgeries (various CPT codes)	Other: Incorrect payment was calculated for multiple surgeries that took place during the same surgical session.	CMS Claims Processing Manual 100-04, Chapter 12, Section 40.6 clarifies instructions on billing for multiple surgeries. This can be found at: http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf .	Florida	\$1.2 million
Lab, Ambulance, and DME Claims				
Ambulance Transfer (HCPCS codes A0422, A0425, A0427, A0428)	Other: During an inpatient hospital stay, all ambulance services received during the stay are included in the hospital payment and should not be billed separately	CMS Benefit policy Manual 100-2, Chapter 10, Section 3.3 clarifies coverage instructions regarding ambulance services. This section can be found at: http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf	California	\$2.6 million
DME services during a hospital stay (various codes)	Other: During an inpatient hospital or SNF stay, all DME services received during the stay are included in the hospital or SNF payment and should not be billed separately.	CMS Claims Processing Manual 100-4, Chapter 20 clarifies billing guidelines for DME services during an inpatient stay.	New York	\$1.5 million
		This section can be found at: http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf	California	\$1.7 million