

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



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section for more details

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Archive of Previously-Issued Newsletters

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

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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 on how to submit accurately coded claims that meet Medicare guidelines. Despite actions to prevent improper payments, such as pre-payment system edits and limited medical record reviews by the claims processing contractors, it is impossible to prevent all improper payments due to the large volume of claims.

The Centers for Medicare & Medicaid Services (CMS) issues the “Medicare Quarterly Provider Compliance Newsletter,” a Medicare Learning Network® (MLN) educational product, to help providers understand the major findings identified by 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 second issue in the third year of the newsletter.

This issue includes 6 findings identified by Recovery Auditors. This educational tool is designed to help FFS providers, suppliers, and their billing staffs understand their claims submission problems and how to avoid certain billing errors and other improper activities when dealing with the Medicare FFS program. An archive of previously-issued newsletters is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MedQtrlyCompNL_Archive.pdf on the CMS website.

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 is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MedQtrlyCompNL_Index.pdf on the CMS website. In addition, a newly-enhanced index is now available that provides a listing of all Recovery Auditor and CERT Review Contractor findings from previous newsletters. The index is customized by specific provider types to help providers quickly find and learn about common billing and claim review issues that impact them directly. For more information, visit the newsletter archive at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyCompNL_Archive.pdf on the CMS website.

Recovery Audit Finding: Hospice Related Services - Part B

Provider Types Affected: Physician Services

Problem Description: Services related to a Hospice terminal diagnosis provided during a Hospice period are included in the Hospice payment and are not paid separately. For beneficiaries enrolled in hospice, Medicare Administrative Contractors (MACs) and/or Medicare Carriers must deny any service furnished on or after January 1, 2002, that are submitted without either GV or GW modifier.

Recovery Auditor Finding: In this audit, the recovery auditors conducted an automated review of claims for physician services. A significant number were deemed to contain improper billing resulting in overpayment.

Claim Example 1: A patient is enrolled in Hospice and goes to a physician's office for open treatment of a femoral fracture, with internal fixation or prosthetic replacement, CPT code 27236.

Finding: If the procedure is unrelated to the terminal diagnosis (Non-Hospice related), the physician's bill should contain modifier GW. If this modifier is not appended, the procedure is related to the terminal diagnosis and should not be reimbursed under the part B benefit, instead paid under the hospice benefit.

Claim Example 2: The patient is shown as being on hospice starting August 1, 2010, through August 31, 2010. A provider billed CPT code 45378, Colonoscopy, with no modifiers to Part B on August 3, 2010.

Finding: The billing of code 45378 would be incorrect since the beneficiary was enrolled in hospice. There can be no separate reimbursement unless the service was unrelated to the terminal diagnosis, which has to be reflected by the proper modifier.

Guidance on How Providers Can Avoid These Problems

The provider should check Medicare's Common Working File to see if the beneficiary is enrolled in Hospice and to see if the procedure was unrelated to the terminal diagnosis (Hospice related).

- ✓ If the claim was unrelated to the terminal diagnosis, the appropriate modifier would be appended to the claim line.
- ✓ If the claim was related, then the claim is not payable under the part B benefit.

Resources:

- ✓ Medicare Learning Network® **Hospice Payment System Fact Sheet** provides information on the Hospice Payment system and is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/hospice_pay_sys_fs.pdf on the CMS website.
- ✓ The CMS Hospice Center is available at <http://www.cms.gov/Center/Provider-Type/Hospice-Center.html> on the CMS website.

- ✓ The "Medicare Claims Processing Manual," Chapter 11, Sections 10, 40.2, and 50, explains hospice claims processing and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c11.pdf> on the CMS website.
- ✓ The "Medicare Benefit Policy Manual," Chapter 9, Section 10, 40.1.9, explains coverage of hospice services under hospital insurance. It is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf> on the CMS website.



Recovery Audit Finding: Back & Neck Procedures excluding Spinal Fusion

Provider Types Affected: Inpatient Hospitals

Problem Description: The recovery auditors conducted complex review of claims with Medicare Severity Diagnosis Related Group (MS-DRG) 491, Back & Neck Procedures excluding Spinal Fusion. Medicare pays for inpatient hospital services that are medically necessary for the setting billed. Medical documentation was reviewed to determine whether the services were medically necessary for the setting billed. According to the "Medicare Benefit Policy Manual," Chapter 1, Section 10, patients covered under hospital insurance are entitled to have payment made on their behalf for inpatient hospital services.

The physician or other practitioner responsible for a patient's care at the hospital is responsible for deciding whether the patient should be admitted as an inpatient. Factors to be considered when making the decision to admit include such things as:

- ✓ The severity of the signs and symptoms exhibited by 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.

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

Finding: In reviewing claims for MS-DRG 491, recovery auditors found a significant percentage of claims to be not medically necessary for the setting billed, resulting in overpayments that had to be recovered.

Example 1: Patient is a 74-year-old female who presented to the hospital for an elective spinal procedure. The patient complained of back pain with radiation to the right leg which has been ongoing for the past 20 years. Per patient the pain was extremely bad for the past year. The patient had tried physical therapy and injections in the past with no relief. Pain rated as follows: Neck 0/10, Right Arm 0/10, Left Arm 0/10, Back 8-9/10, Right Leg 6/10, Left Leg 0/10. Patient reports back pain is constant and getting worse. Denies numbness, pins and needles or weakness. Reports good control of bowel and bladder. Spends usual waking hours lying down. Bending, lifting, twisting, reaching, coughing and sneezing bother the patient. The patient has failed conservative efforts and wishes to proceed with spinal surgery. An MRI of the lumbar spine revealed right foraminal disk herniation at L4-5 with neural canal stenosis.

The patient's past medical history includes hypertension, lumbar disc disease, chest pain, "leaky" heart valve and numerous previous orthopedic surgeries. The patient's

blood pressure upon admission was 168/67, pulse 56, respirations 20, temperature 97.2, with oxygen saturation 97% on room air. The patient was noted to be awake, alert and oriented upon examination. Cranial nerve examination was normal. The patient had normal muscle tone with normal strength in all muscle groups. There was tenderness in the lumbosacral region and spasm in the paraspinal lumbosacral muscles. Preoperative laboratory studies were obtained and revealed WBC 11.0, hemoglobin 14.1, hematocrit 42.7, platelets 280, glucose 89, BUN 15, creatinine 1.1, sodium 141, potassium 4.6, bicarbonate 27, PT 12.1, PTT 29.7, INR 1.0.

The patient was scheduled for surgical treatment. The physician's planned treatment was to perform an elective extra-foraminal decompression on the right L4-L5 and partial facetectomy on the right at the L4-L5. Patient was admitted to the hospital and taken to surgery on August 19, 2008, for lumbar decompression laminectomy right L4-L5. On August 20, 2008, the vital signs were stable. The patient states that her back pain has improved and her leg pain has improved as well. Denies any chest pain, nausea, vomiting or fever. The procedure was performed without incident and the patient experienced no complications. Patient was discharged home with follow-up information and appropriate medication. DRG: 491; 722.10 (Displacement of Lumbar Intervertebral Disc w/o Myelopathy; 401.9 (HTN; Unspecified); 724.02 (Spinal Stenosis; Lumbar Region) Procedure Code: 80.51 (Excision of Intervertebral Disc)

Finding: This patient did not meet criteria for an inpatient admission due to:

- ✓ Patient did not experience any intraoperative or post-op complications; and
- ✓ Recovery phase was within expectations for this procedure.

Example 2: Patient is a 79-year-old male who presented to the hospital for an elective left L4-5 foraminotomy and discectomy. MRI revealed foraminal stenosis on the left at L4 and primarily at L5 with compression of those nerve roots. Past medical history includes arthritis, cataracts, hypercholesterolemia, hypertension and scoliosis. The patient's vital signs upon admission were temperature 98, pulse 61, respirations 20, blood pressure 135/60, and oxygen saturation 100% on room air. Pre-admission laboratory data revealed WBC 10.4, hematocrit 38.4, BUN 43 and creatinine 2.16. The patient received medical clearance for this surgery.

Complains of severe lower lumbar pain with intermittent tingling and numbness in the left leg and left big toe. Patient has a left-sided foot drop and states over the last few months he has had progressively worsening left leg pain and foot weakness. He has been treated with some epidural steroid injects with essentially no relief of his left leg pain. He reports some right-sided symptoms but those were relieved with epidural steroid injections. He describes an aching sensation with radiation from his buttock, down his hamstrings onto the top of his foot. He also notes significant left leg weakness. His daughter reports he has been so unsteady on his feet that he fell recently and fractured his right patella. The physician

discussed surgical intervention with patient and his daughter, including the risks, benefits, and alternatives of this surgical intervention. Given his profound foot drop, he is to consider fairly urgent surgical intervention.

The patient underwent L4 medial fasciectomy, foraminotomy and discectomy and L5 medial fasciectomy with foraminotomy without complications. Post-operatively, the patient had mild incisional pain with no leg pain and sensation was grossly intact. The patient was discharged home and instructed to follow-up with his physician in 1-2 weeks. Final diagnosis is lumbar stenosis. Procedure is lumbar foraminotomy. Instructions are to resume preoperative medications. DRG: 491: 722.10 (Displacement of Lumbar Intervertebral disc w/o Myelopathy); 401.9 (HTN, unspecified); 272.0 (Disorders of Lipoid metabolism, pure Hypercholesterolemia); 530.81 (Esophageal Reflux); 412 (MI, Old); 414.01 (CAD, Native Artery) Procedure Code: 80.51 (Excision of Intervertebral Disc); 03.09 (Other Exploration and Decompression of Spinal Canal).

Finding: This patient did not meet criteria for an inpatient admission due to:

- ✓ Patient did not experience any intraoperative or post-op complications; and
- ✓ Recovery phase was within expectations for this procedure.

Guidance on How Providers Can Avoid These Problems:

- ✓ Hospitals and physicians are encouraged to review MLN Matters® SE1037 Guidance on Hospital Inpatient Admission Decisions, which is available

at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1037.pdf> on the CMS website. This article provides guidance on hospital inpatient admission decisions.

- ✓ The "Medicare Benefit Policy Manual," Chapter 1, discusses inpatient hospital admission requirements and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf> on the CMS website.

Resources:

- ✓ The "Medicare Program Integrity Manual," Chapter 6, Section 6.5.2.A, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf> on the CMS website. This section of the manual states that inpatient care is required only if the patient's medical condition, safety or health would be significantly and directly threatened if care were provided in a less intense setting.
- ✓ The "Medicare Benefit Policy Manual," Chapter 10, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf> on the CMS website. This section of the manual explains that the physician determines whether the patient needs inpatient care and gives criteria for this choice.

Recovery Audit Finding: Syncope and Collapse

Provider Types Affected: Inpatient Hospitals

Recovery Auditor Review and Finding: Medicare only pays for inpatient hospital services that are medically necessary for the setting billed and that are coded correctly. In this instance, the recovery auditors performed complex reviews of the medical records and documentation for Medicare Severity Diagnostic Related Group (MS-DRG) 312, Syncope and Collapse, to determine whether the services were medically necessary and were billed correctly. This review was completed by a licensed clinician, such as a nurse, therapist or physician.

Of the claims reviewed, the recovery auditors found a significant percentage that were improperly billed, resulting in overpayments that had to be recovered.

Example 1: A 77-year-old female with history of chronic bowel problem of constipation. Per information in history and physical, she had severe straining with a bowel movement and passed out immediately after in the bathroom. No injury. Was feeling completely fine and sent to the Emergency Department. The patient was admitted on November 2, 2009, and discharged on November 3, 2009. Per History and Physical, has had prior cardiac workup in the past for similar symptoms. No significant history. All other systems negative. Alert oriented x3, no distress. Vitals stable. Heart regular rate and rhythm. Chest x-ray no acute process, CT of brain unremarkable. Carotid Doppler, no lesions. Labs

unremarkable. Discharge summary: syncope extremely suggestive and essentially pathognomonic of vasovagal syncope.

Finding: The signs and symptoms documented were not significant or severe enough to warrant the need for medical care at the intensity of an inpatient admission. The signs and symptoms documented at time of entry into the medical facility were resolved prior to the admission order being written. The medical record does not establish the need for acute care hospitalization at an inpatient level. The admission was denied because the medical record does not establish the need for acute care hospitalization at an inpatient level.

Example 2: A 68-year-old female who presented to the Emergency Department after two or three “drop attacks” within last 36 hours. Feels weak and collapses. No known loss of consciousness. No abnormalities found. Patient had no further symptoms. The patient was admitted on December 21, 2009, and discharged on December 22, 2009. Has history of at least two seizures 2 years ago related to right hemispheric stroke. History of chronic hypertension, hiatal hernia and gastroesophageal reflux. Was seen recently in the Emergency Department with subtherapeutic Dilantin level. At that time Dilantin dose was increased. On this visit, the Dilantin level was 21. Patient states she has been getting weaker since change in Dilantin dose. Feels weak and collapses. No known

loss of consciousness. Vital signs: blood pressure, 119/59; pulse, 61; respirations, 18; temperature, 98.2; oxygen saturation, 97% room air. CT of brain, no abnormality. Echocardiogram shows mild hypertrophy and mild regurgitation, borderline pulmonary hypertension. Carotid ultrasound, no abnormalities. Patient had no further symptoms.

Finding: The signs and symptoms documented were not significant or severe enough to warrant the need for medical care at the intensity of an inpatient admission. Evaluation and treatment could have been rendered in an observation status. The inpatient admission was denied because the medical record does not establish the need for acute care hospitalization at an inpatient level.



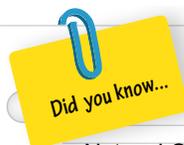
Discussion: The recovery audit finds that inpatient requirements have not been met. The "Medicare Program Integrity Manual," Chapter 6, Section 6.5.2.A, states that inpatient care is required only if the patient's medical condition, safety or health would be significantly and directly threatened if care were provided in a less intense setting.

Guidance on How Providers Can Avoid These Problems:

Hospitals and physicians are encouraged to review MLN Matters® SE1037 Guidance on Hospital Inpatient Admission Decisions, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1037.pdf> on the CMS website. This article provides guidance on hospital inpatient admission decisions.

Resources:

- ✓ The "Medicare Program Integrity Manual," Chapter 6, Section 6.5.2.A, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf> on the CMS website. This section of the manual states that inpatient care is required only if the patient's medical condition, safety or health would be significantly and directly threatened if care were provided in a less intense setting.
- ✓ The "Medicare Benefit Policy Manual," Chapter 10, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf> on the CMS website. This section of the manual explains that the physician determines whether the patient needs inpatient care and gives criteria for this choice.



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Recovery Audit Finding: Other Operative Room Procedures for Injuries

Provider Types Affected: Inpatient Hospitals

Problem Description: Other Operative Room (OR) Procedures for Injuries is one of the top surgical Diagnostic Related Groups (DRG) in the Program for Evaluating Payment Patterns (PEPPER) Nationwide Target Area Summary that has the potential for error. Therefore, MS-DRGs 907, Other OR Procedures for Injuries with Major Complications or Comorbidities (MCC), DRG 908, (Other OR Procedures for Injuries with Complications or Comorbidities (CC), and DRG 909, Other OR Procedures for Injuries without CC/MCC were selected to determine if the principal, secondary diagnoses and procedures were assigned inappropriately resulting in payment errors to the hospitals. An analysis of the billing data indicates that a potential aberrant billing practice may exist for these MS-DRGs.

Finding and demand: The recovery auditors conducted complex review of medical records for MS-DRG validation cases. The purpose of the review was 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 affects the stay. The Present on Admission (POA) indicator for all

diagnoses reported must be coded correctly. Reviewers validated for MS-DRG 907, 908, 909, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG.

The recovery auditors found a considerable percentage of claims that were incorrectly coded, which resulted in several overpayments.

Example 1: A 68-year-old female was admitted with severe abdominal pain and low grade fever with a past medical history of chronic kidney disease stage 4 and anemia related to the chronic kidney disease. History of present illness notes a recent colonoscopy and the patient had a Tenckhoff dialysis catheter placed prior to this admission. It was noted on admission that she recently had a colonoscopy and was worked up for her abdominal pain. The final diagnosis was peritonitis associated with Tenckhoff catheter. The catheter was flushed and 700 white cells were noted. She was started on broad spectrum antibiotics for the peritonitis. The patient was discharged home on the fourth hospital day on oral antibiotics. The final diagnosis was peritonitis associated with peritoneal dialysis catheter, chronic kidney disease stage 4, and anemia related to chronic kidney disease.

Coding problem: A procedure was coded without evidence of the procedure being performed during this admission or within three days prior to admission. The claim was

coded with procedure code 54.93, Creation of cutaneoperitoneal fistula. This code was deleted as there was no evidence of the fistula being created on this admission. This resulted in a change of MS-DRG from 907 to 919, Complications of Treatment with MCC. This change resulted in an overpayment. Source of coding change is the official coding guidelines for reporting procedures.

Example 2: An eighty-year-old female was admitted with a right periorbital retrobulbar hematoma after suffering from an orbital floor blowout fracture nine days prior to admission that had been repaired in a prior inpatient stay. CT scan revealed a retrobulbar hematoma impinging on the optic nerve and that hematioma led to the current admission. The patient was taken to the operating room where an open decompression of the right retrobulbar hematoma and a lateral canthotomy were performed. The patient was placed on IV steroids and four days after the evacuation procedure was brought back to the operative room for a lateral canthopexy with a complex closure of the right lower lid. The final diagnosis was right periorbital retrobulbar hematoma.

Coding problem: An acute fracture code was coded during a subsequent episode of care after the fracture was initially treated. This claim was billed with a secondary diagnosis of 802.6, Fracture Orbital Floor-Closed. This code was

deleted as this admission was not the initial admission and treatment of the fracture. Coders should only code procedures performed during the inpatient admission. For billing purposes, the outpatient procedure may be billed on the inpatient claim if performed within three days of the inpatient admission. In this case, there is no evidence of when the procedure was performed as no operative report was submitted.

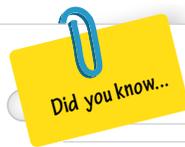
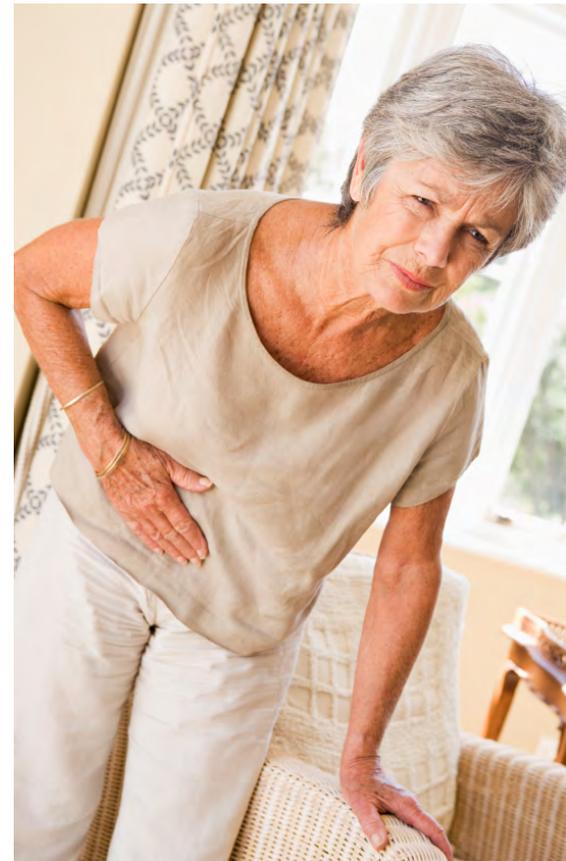
Subsequent encounters require the use of an orthopedic after care code. According to coding clinic fourth quarter 2002, coding guidelines for the ICD-9-CM require that a fracture code be used only for an initial encounter for treatment. Subsequent encounters require the use of an orthopedic aftercare code. In this case, the fracture had already been treated with surgical intervention on a previous admission and the acute fracture code should not have been coded. This deletion resulted in a change of MS-DRG change to 908 to 909, Other Operative Room procedures without CC/MCC. This change resulted in an overpayment.

Source of coding change is the Coding Clinic Fourth Quarter 2002. Three new subcategories and many new codes have been created to greatly expand the detail in the aftercare codes. Major changes were made to the orthopedic aftercare codes. Coding guidelines for the ICD-9-CM require that a fracture code be used only for an initial encounter for treatment. Subsequent encounters require the use of an orthopedic aftercare code. The problem was that the aftercare code provided very little detail. To remedy this, subcategories V54.1, Aftercare for healing traumatic fracture, and V54.2, Aftercare for healing pathologic fracture, were created. The codes under these

subcategories identify the site of the fracture. It is not necessary to assign code V54.19, Aftercare for healing traumatic fracture of other bone, or code V54.29, Aftercare for healing pathologic fracture of other bone, more than once if several bones in the same subcategory are involved. A new code has also been created for aftercare following joint replacement, V54.81.

Guidance on How Providers Can Avoid These Problems:

- ✓ Coders should only code procedures performed during the inpatient admission. For billing purposes, the outpatient procedure may be billed on the inpatient claim if performed within three days of the inpatient admission.
- ✓ Follow all coding clinic and official coding guidelines on when to report the acute fracture code. Report aftercare codes for subsequent episodes of care.



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](#).

Recovery Audit Finding: Visits to Patients in Swing Beds

Provider Types Affected: Physicians Services

Problem Description: Providers are inappropriately billing hospital visit codes for Evaluation and Management (E&M) services rendered in swing bed facilities (with nursing facility levels of care) when they should be billing nursing facility visit E&M codes, which properly define the type of care provided in a swing bed setting. This problem was identified through review of previous Comprehensive Error Rate Testing (CERT) reports indicating high percentage of errors on E&M services.

Recovery Auditor Finding: The recovery auditors conducted automated reviews of E&M services rendered in swing bed facilities and found a significant number of claims that were incorrectly billed, with resulting overpayments.

Claims Example 1: An 86-year-old female was admitted to a hospital with swing bed approval for nursing facility care on November 2, 2010, and was discharged on November 30, 2010. A physician billed Current Procedural Terminology (CPT) Code 99231 (Subsequent hospital care) for date of service November 3, 2010.

Finding: The date of service, November 3, 2010, is during the stay for nursing facility care at a swing bed approved facility and data analysis confirms that the patient was not on a leave-of-absence from the hospital on that date. The CPT Code 99231 on the claim resulted in the overpayment.

Claims Example 2: A 92-year-old female was admitted to a hospital with swing bed approval for nursing facility care on April 30, 2010, and was discharged on May 6, 2010. A physician billed CPT Code 99232 (Subsequent hospital care) for date of service May 5, 2010.

Finding: Date of service May 5, 2010, is during the stay for nursing facility care at a swing bed approved facility and data analysis confirms that the patient was not on a leave-of-absence from the hospital on that date. The CPT Code 99232 was inappropriate and resulted in the overpayment.

Guidance on How Providers Can Avoid These Problems:

- ✓ Develop or enhance edits to identify hospital care codes billed while the patient was admitted to a hospital with swing bed approval for nursing facility care.
- ✓ Increase provider awareness regarding the correct use of nursing facility codes. CPT Codes 99221-99223 (Initial Hospital Care), 99231-99233 (Subsequent Hospital Care) and 99238-99239 (Hospital Discharge Day Management) were reviewed in this audit.

Resources:

- ✓ MLN Matters® Article Number MM7405, available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7405.pdf> on the CMS website, clarifies E&M payment policies.
- ✓ 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 on the CMS website.
- ✓ The "Medicare Claims Processing Manual," Chapter 12, Section 30.6.9 is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf> on the CMS website. This section of the manual discusses Evaluation & Management Services.



Recovery Audit Finding: Other Musculoskeletal System and Connective Tissue O.R. Procedure with CC

Provider Types Affected: Inpatient Hospitals

Problem Description: MS-DRG validation and medical necessity reviews were performed to substantiate the need for inpatient admission versus observational level of care for patients with diagnosis of Medicare Severity Diagnosis Related Group (MS-DRG) 516, Other musculoskeletal system & connective tissue operating room (O.R.) procedures with complicating conditions (CC).

The recovery auditors reviewed documentation to validate the medical necessity of short stay, uncomplicated admissions following elective scheduled surgeries. Medicare only pays for inpatient hospital services that are medically necessary for the setting billed and that are coded correctly. Medical documentation was reviewed to determine that the services were medically necessary and were billed correctly for MS-DRG 516.

The recovery auditors also reviewed documentation for DRG Validation for MS-DRG 516, requiring that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matched both the attending physician description and the information contained in the beneficiary's medical record. Reviewers validated for MS-DRG, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG.

Finding: The recovery auditors found a number of claims that were incorrect, which lead to overpayments.

Here are two examples of "wrong setting" improper payments.

Example 1: A 69-year-old female was admitted on April 11, 2011, with complaint of two months of low back pain with some right lower extremity pain that followed the L5 or S1 myotomal distribution. Admitting diagnoses were severe tobacco abuse, severe osteoporosis, and osteoporotic L5 compression fracture. Patient was noted to be a heavy smoker who still worked full-time at a day care facility. Patient stated she performs no heavy lifting at work.

The patient had prior history of lower thoracic and upper lumbar compression fractures that occurred approximately 5 years prior. These were treated successfully with vertebroplasty treatments. The patient had outpatient MRI performed on March 18, 2011, that revealed degenerative spondylolisthesis of L4 on L5. She also had a subacute compression fracture of L5 vertebral body with approximately 30-40 percent compression of the superior endplate at L5.

The patient was scheduled for an elective kyphoplasty of lumbar 5 segment on the day of admission. Postoperatively, the patient did remarkably well. Patient noticed immediate improvement

in her pain. She even noted improvement of the right lower extremity pain and numbness. Patient was discharged the following day and was to follow-up in one week for suture removal.

Example 2: An 82-year-old female was admitted with complaint of low back pain after sustaining a fall 3 weeks prior to surgical date. Admitting diagnoses were compression fractures of T11 and L3, GERD, NIDDM, intention tremor, hypothyroidism, and abdominal aneurysm, status post splitting. Patient stated pain worsens with transitioning from a sitting to a standing position. Patient had an outpatient MRI that revealed compression fractures of T11 and L3. Patient had discussion with surgeon regarding conservative treatment with bracing, physical therapy and medications versus operative management. The patient decided to proceed with surgery. She was admitted on January 17, 2011, for an elective kyphoplasty. Patient had an uncomplicated operative course and deemed stable for discharge several hours after the procedure. Patient was instructed to follow up in 2 weeks for wound check.

Finding and Discussion: In both of these examples, the recovery auditor finds that the requirements for inpatient status as outlined in Medicare's regulatory documents have not been met. The "Medicare Program Integrity Manual,"

Chapter 6, Section 6.5.2.A, states that inpatient care rather than outpatient care is required only if the patient's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. Elective, scheduled, non emergent kyphoplasties for compression fractures in patients who are able to have pre-operative medical clearance by anesthesia or internal medicine and who have a low probability of complications during the operative procedure can be performed on an outpatient or observational level of care.

Medical necessity of inpatient care is discussed in the "Medicare Benefit Policy Manual," Chapter 1, Section 10. Patients covered under hospital insurance are entitled to have payment made on their behalf for inpatient hospital services. 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. Factors to be considered when making the decision to admit include such things as the severity of the signs and symptoms exhibited by 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.

Guidance on How Providers Can Avoid These Problems:

Providers should review the pertinent Medicare manual provisions regarding inpatient medical necessity requirements. Patients who have scheduled, elective kyphoplasties for non-emergent compression fractures may be able to have these surgeries performed in an outpatient or observation status. This may be the case especially when the patient's chronic medical conditions can be optimized. Also, with pre-operative clearance, the predictive risk of complications is diminished and, therefore, elective kyphoplasties may be able to be performed in an outpatient or under observation status.

Resources:

- ✓ Recovery Audit Contractor (RAC) Demonstration Project Report: The RAC Demonstration Project Report may be viewed at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/downloads/RACEvaluationReport.pdf> on the CMS website.
- ✓ The "Medicare Program Integrity Manual," Chapter 6, Section 6.5.2.A, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf> on the CMS website. This document discusses requirements for inpatient status.
- ✓ The "Medicare Benefit Policy Manual," Chapter 1, Section 10, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf> on the CMS website. This document addresses medical necessity of inpatient care.

