

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



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# Medicare Quarterly Provider Compliance Newsletter Guidance to Address Billing Errors



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section for more details

Volume 4, Issue 1 - October 2013

ICN 908950/ October 2013

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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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ICD-9-CM Notice: The International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official Federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act standard.

# Introduction

The Medicare Fee-For-Service (FFS) program contains a number of payment systems, with a network of contractors that processes more than one billion claims each year, submitted by more than one 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 are called Medicare Administrative Contractors (MACs) and they process claims, make payments to health care professionals 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 first issue in the fourth year of the newsletter.

This issue includes five findings identified by Recovery Auditors and two items related to CERT findings. 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](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MedQtrlyCompNL_Archive.pdf) on the CMS website.

This newsletter describes the problems, the issues that may occur as a result, the steps CMS has taken to make providers aware of the problems, and guidance on what providers need to do to avoid the issues. In addition, the newsletter refers providers to other documents for more detailed information wherever that 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](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](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyCompNL_Archive.pdf) on the CMS website.

## Comprehensive Error Rate Testing (CERT): Clinic End-Stage Renal Disease (ESRD) Services

**Provider Types Affected:** ESRD Facilities

**Background:** The Comprehensive Error Rate Testing (CERT) program's reviews of claims for Clinic ESRD services have consistently yielded high improper payment rates. Claims for Clinic ESRD services selected by CERT included Part A non-DRG claims with the two digit type of bill (TOB) 72 (Renal Dialysis Facility (RDF)).

"End Stage Renal Disease is a kidney impairment that is irreversible and permanent and requires either a regular course of dialysis or kidney transplantation to maintain life. Dialysis is the process of cleaning the blood and removing excess fluid artificially with special equipment when the kidneys have failed." (Federal Register (FR) Vol. 73, No. 73, Tuesday April 15, 2008).

**Problem Description:** Clinic ESRD services had an improper payment rate of 4.9 percent during the November 2011 Report Period with a projected improper payment amount of \$398 million. The improper payment rate was 5.3 percent during the November 2012 Report Period with a projected improper payment amount of \$523 million. Most of the improper payments for Clinic ESRD claims are due to insufficient documentation. The specific element of the medical record most often incomplete or not authenticated is the patient plan of care. Often, the patient plan of care references a protocol (or algorithm) for treatment or laboratory

investigations that is missing or outdated.

**Example:** A beneficiary received a month of dialysis services at a Clinic ESRD, and the claim was sampled by CERT. Medical records submitted for review included progress note reports, a form labeled Medication Orders, dialysis flow sheets, a form labeled Ordered Labs Report, a Medication Summary Report, and a Biochemical Lab Report for the month of service dated March 19, 2012—April 30, 2012. The medical records provided in response to a request for additional documentation, included duplicates of documentation previously submitted. No response was received after an additional call requesting more documentation to support the claim.

**CERT Finding:** Specifically, the documentation submitted did not contain valid physician's orders for dialysis and medications. Therefore, the claim was scored an improper payment due to insufficient documentation to meet Medicare documentation requirements.

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

- ✓ According to Title 42 of the Code of Federal Regulations (CFR), Section 413.210(a), to qualify for payment, ESRD facilities must meet the conditions for coverage in part

494. Per 42 CFR 494.80(d), the ESRD patient's comprehensive reassessment and revision of the plan of care must be conducted at least annually for stable patients and at least monthly for unstable patients. Per 42 CFR 494.80(a), the patient's comprehensive assessment must include, in addition to other elements, an evaluation of factors associated with anemia, such as hematocrit, hemoglobin, iron stores, and potential treatment plans for anemia, including administration of erythropoiesis-stimulating agent(s). 42 CFR 494.90(b) states that the patient's plan of care must be signed by team members, including the patient or the patient's designee.

- ✓ Implementation of the initial plan of care must begin within the latter of 30 calendar days after admission to the dialysis facility or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session. Implementation of monthly or annual updates of the plan of care must be performed within 15 days of the completion of the patient reassessments specified in 42 CFR 494.80(d).
- ✓ The dialysis facility must ensure that all dialysis patients are seen by a physician, nurse practitioner, clinical nurse specialist, or physician's

assistant providing ESRD care at least monthly, as evidenced by a monthly progress note placed in the medical record, and periodically while the hemodialysis patient is receiving in-facility dialysis.

**Resources:**

Providers who would like more information on avoiding improper payments for ESRD facility claims can visit or refer to:

- [42 CFR 413.210\(a\)](#) (Qualifications for payment)
- [42 CFR 494.80\(d\)](#) (Condition: Patient Assessment)
- [42 CFR 494.90\(b\)](#) (Condition: Patient Plan of Care)
- MLN Matters® article MM7869 (Implementation of Changes to the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) Consolidated Billing Requirements for Daptomycin and a Clarification of Outlier Services for Calendar Year 2013) at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7869.pdf> on the CMS website; and
- The “Medicare Claims Processing Manual” (Chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims) at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf> on the CMS website.



**Did you know...**

The Medicare Learning Network® (MLN) has released a new package of products designed to educate physicians and other Medicare and Medicaid providers about medical identity theft and strategies for addressing it. These products include a web-based training course that is approved for Continuing Education (CE) and Continuing Medical Education (CME) credit. For more information, visit the MLN Provider Compliance web page at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html> and click on the ‘Medicaid Program Integrity: Safeguarding Your Medical Identity Educational Products’ link under ‘Downloads’ at the bottom of the page.

## Comprehensive Error Rate Testing (CERT): Immunosuppressive Drugs

**Background:** Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) and Comprehensive Error Rate Testing (CERT) program reviews of claims for immunosuppressive drugs have consistently yielded high improper payment rates. During the November 2011 Report Period, the improper payment rate for immunosuppressive drugs was 55.4% with a projected improper payment amount of \$218 million. The improper payment rate for immunosuppressive drugs was 50.4 percent during the November 2012 Report Period with a projected improper payment amount of \$193 million. The following discussion presents coverage requirements for claims for immunosuppressive drugs, examples of improper payments for immunosuppressive drugs, the common causes of improper payments for immunosuppressive drugs, and resources for providers.

### Requirements for Claims for Immunosuppressive Drugs:

The Social Security Act, Section 1861(s)(2)(J) (which you can find at [http://www.ssa.gov/OP\\_Home/ssact/title18/1861.htm](http://www.ssa.gov/OP_Home/ssact/title18/1861.htm)) and 42 Code of Federal Regulations (CFR) 410.30 (which you can find at <http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=001a9bcb014e0bb865c31cbcd37da1af&rqn=dv8&view=text&node=42:2.0.1.2.10.2.35.19&idno=42>) provide for the coverage of prescription drugs for immunosuppressive therapy furnished to an individual who receives an organ transplant for which Medicare payment is made.

Further, Medicare statute and benefit category language narrowly define, and closely regulate, the coverage of immunosuppressive drugs; and stipulate that immunosuppressive drugs are eligible for reimbursement only when all of the following criteria are met:

- I. Immunosuppressive drugs are prescribed following either:
  - A. Kidney (V42.0), heart (V42.1), liver (V42.7), bone marrow (V42.81)/stem cell (V42.82), lung (V42.6), or heart/lung (V42.1 and V42.6) transplant; or,
  - B. Whole organ pancreas (V42.83) transplant performed concurrent with or subsequent to a kidney transplant (V42.0) because of diabetic nephropathy (performed on or after July 1, 1999); or,
  - C. Intestinal transplant (V42.84) (performed on or after April 1, 2001); or,
  - D. Pancreatic islet cell transplant (V42.89) or partial pancreatic tissue transplantation (V42.89) performed on or after October 1, 2004 that is conducted as part of a National Institutes of Health (NIH)-sponsored clinical trial; or,
  - E. Pancreas transplants alone (performed on or after April 26, 2006) that meet the following criteria:
    1. The transplant is performed in a facility that

is Medicare-approved for kidney transplantation; and

2. Beneficiary must have a diagnosis of type I diabetes and:
  - a. Must be beta cell autoantibody positive; or,
  - b. Must demonstrate insulinopenia, (fasting C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method). A fasting glucose must be obtained when performing a fasting C-peptide determination. Fasting C-peptide levels are considered valid when a concurrently obtained fasting glucose is <225 mg/dL; and,
3. Must have a history of labile (brittle or medically-uncontrollable) insulin-dependent diabetes mellitus resulting in documented recurrent, severe, acutely life-threatening metabolic complications requiring hospitalization(s). Complications may include frequent hypoglycemia where the beneficiary is unaware, recurring severe ketoacidosis, or recurring severe hypoglycemic attacks; and,
4. Must have been under the care of an endocrinologist and have clinical

documentation denoting optimal and intensive management was provided for at least 12 months, having received the most medically-recognized advanced insulin formulations and delivery systems; and,

5. Must demonstrate being able to emotionally and mentally understand the significant risks associated with surgery and be able to effectively manage the lifelong need for immunosuppression; and,
6. Must otherwise be a suitable candidate for transplantation; and

II. The transplant met Medicare coverage criteria in effect at the time (e.g., approved facility for kidney, heart, intestinal, liver, lung, or heart/lung transplant; national and/or local medical necessity criteria; etc.); and,

III. The beneficiary was enrolled in Medicare Part A at the time of the transplant; and,

IV. The beneficiary is enrolled in Medicare Part B at the time that the drugs are dispensed; and,

V. The drugs are furnished on or after the date of discharge from the hospital following a covered organ transplant.

If criteria I-V are not met, the drug(s) will be denied as noncovered.

If criteria I, II, and III are met, the transplant is considered a "covered transplant" for purposes of this

policy whether payment for the transplant was made by Medicare or by another insurer.

### **Examples of Improper Payments Due to Insufficient Documentation:**

In order for a beneficiary's immunosuppressive drugs to be eligible for reimbursement, the reasonable and necessary requirements set out in relevant Local Coverage Determinations must be met.

Most of the improper payments for claims for immunosuppressive drugs reviewed by CERT, were due to insufficient documentation. Below are two examples of improper Medicare payment resulting from insufficient documentation.

**Example 1:** A pharmacy provided immunosuppressive drugs, tacrolimus (J5707) and mycophenolate mofetil (J7517), for a beneficiary in March of 2010. Medicare paid the pharmacy for the medications and paid a dispensing fee. The medical records received for review did not include a valid signed and dated order for the medications or documentation to support that the beneficiary had a transplant. Nor was there any medical documentation supporting the need for beneficiary's continued requirement for the drugs as ordered. In response to a request for additional documentation, a signed order was received for tacrolimus and mycophenolate mofetil, however the order was not dated.

**CERT Finding:** The claim was scored an improper payment due to insufficient documentation to meet Medicare documentation requirements.

**Example 2:** A pharmacy provided the immunosuppressive drug cyclosporine (J7502), for a beneficiary in July of 2009. Medicare paid the pharmacy for the medications and paid a dispensing fee. The medical records received for review did not include a valid signed and dated order for the medications, or documentation to support that the beneficiary had undergone a kidney transplant. Nor was there any documentation to support the treating physician's continued medical management for a kidney transplant.

In response to a request for additional documentation, a transcript of a verbal order for cyclosporine was received. However, it was not signed by the physician or authenticated by the transcriber.

**CERT Finding:** The claim was scored an improper payment due to insufficient documentation to meet Medicare documentation requirements.

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

- ✓ Most of the improper payments for claims reviewed by CERT for immunosuppressive drugs were due to insufficient documentation. Some of the most common errors that reviewers identified are listed below:

### Detailed Written Order-Related Errors:

- a) Copy of detailed written order was not provided;
- b) Detailed written order was illegible;
- c) The order was missing required elements such as:
  - Beneficiary's name;
  - Name of drug;
  - Dosage;
  - Quantity to be dispensed;
  - Route of administration;
  - Frequency of administration;
  - Physician's name;
  - Refill instructions;
  - Physician signature and date; or
  - The start date of the order, if different than the signature date;
- d) Physician did not personally date his/her signature;
- e) Items were delivered prior to obtaining a detailed written order; and
- f) No written documentation of a dispensing order was provided.

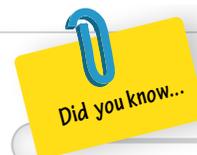
### Medical Record-Related Errors:

- a) Copy of pertinent medical records was not provided;
- b) Medical records did not document that the drug was included in the physician's plan of care for the beneficiary;
- c) Records failed to document continued use and/or medical need for the drug;

- d) The name of the transplant center was not provided;
- e) Records are missing a signature or it is illegible; and/or
- f) Records provided did not document a transplant.

### Resources:

- For questions regarding documentation requirements for immunosuppressive drug claims, you can refer to the relevant LCDs and related Policy Articles from your DME MAC. To do so, visit the following:
  - [Noridian Administrative Services](#);
  - [National Government Services](#);
  - [CGS Administrators, LLC](#); and
  - [NHIC Corp](#) on the CMS website.

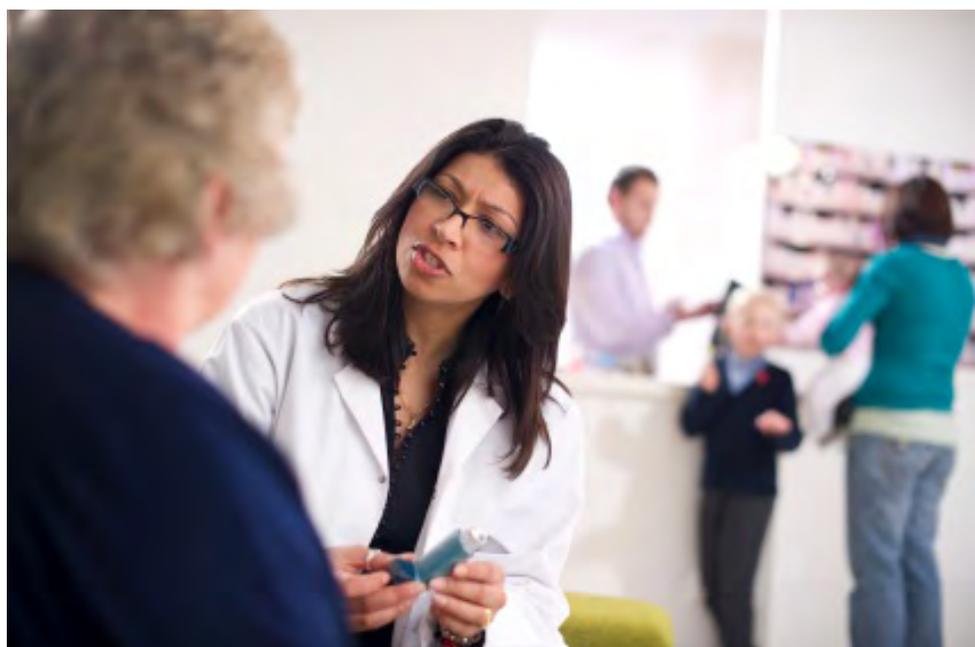


#### Question:

What is the correct principal diagnosis for a patient who suffers an acute myocardial infarction (AMI) due to underlying coronary artery disease (CAD), in which an interventional procedure is carried out? The consultants are advising coders to sequence the AMI as a secondary diagnosis and the CAD as the principal diagnosis for these cases.

#### Answer:

No, the consultant's advice is not correct. Sequence the AMI as the principal diagnosis since it is the acute condition and the reason for the admission. You should continue to follow correct coding and reporting practices and report the AMI as the principal diagnosis. This advice is similar to that published in Coding Clinic, Third Quarter 2009, pages 9-10.



## Recovery Audit Finding: Inappropriate Payment for Vertebral Augmentation Procedure (VAPs)

**Provider Types Affected:** Outpatient Hospital

**Problem Description:** Local Coverage Determination (LCD) policy has indicated specific conditions or diagnoses that are covered for Vertebral Augmentation Procedures (VAPs). Recovery Auditors identified outpatient claims where the first-listed and/or other diagnosis codes do not match to the covered diagnosis codes in the LCD policies.

**Recovery Auditor Finding:** The following two scenarios exemplify reasons for adjustments the Recovery Auditors make in order to align provider payments with Medicare guidelines.

**Example 1:** On March 22, 2011, a provider submitted a claim with Healthcare Common Procedure Coding System (HCPCS) 22521 and diagnosis code 724.2.

**Finding:** This code is not listed on the Payer's LCD as an ICD-9 code that support medical necessity.

**Example 2:** On June 8, 2011, a provider submitted a claim with HCPCS 22524 and diagnosis codes 806.4, 401.9, 782.1, 300.00, V13.02, and 429.3.

**Finding:** The listed diagnosis codes are not on the Payer's LCD as ICD-9 codes that supports medical necessity.

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

- ✓ Documentation supporting the medical necessity such as ICD-9 codes must be submitted with each claim. Claims submitted without such evidence will be denied as being not medically necessary. The medical record must include documentation of the specific signs, symptoms, and condition associated with the billed ICD-9 code. To establish medical necessity the medical record must indicate that other non-invasive corrective medical treatment has been tried and failed. Providers and their billing staff must use LCDs and National Coverage Determinations (NCDs), when they exist, to ensure the medical product, procedure, or service will be covered.

The performance of VAPs is considered to be medically reasonable and necessary when utilized in the treatment of the following conditions:

1. Persistent debilitating pain caused by the recent (e.g. 8 – 12 weeks) pathologic fracture or collapse of noncervical vertebrae.
  - a. Initially, conservative management should be implemented prior to performing a VAP.

Conservative management includes, but is not limited to, immobilization, analgesia, physical therapy, etc.

- b. Exceptions to conservative management may include a high level of pain, disability and neurologic compromise.
2. Painful non-unions of Vertebral Compression Fractures (VCF);
3. Back pain associated with osteolytic metastatic disease involving a vertebral body;
4. Back pain associated with multiple myeloma involving a vertebral body; or
5. Painful hemangiomas.

### Limitations:

1. Coverage for only one procedure per lifetime per vertebra will be allowed. If a repeat procedure on a single vertebra is to be performed, medical record documentation must support the medical necessity of the repeat procedure.
2. Medicare will not provide coverage for procedures performed for asymptomatic VCFs, VCFs responding appropriately to conservative therapy, or for healed VCFs.
3. Bone biopsy is considered integral to the procedures and not separately billable.

- 4. Treatment of kyphosis in the absence of a painful VCF is not covered.
- 5. VAPs is contraindicated in osteomyelitis / discitis involving the vertebral column.

**Resources:**

- To ensure proper payments of VAPS, the LCDs and NCDs should be reviewed, in order to have the covered ICD codes.
- Review the LCD: [Vertebroplasty \(Percutaneous\) and Vertebral Augmentation including cavity creation.](#)
- Review the [LCD Surgery on VAPs.](#)



**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.](#)

## Recovery Audit Finding: Office Visits Billed for Hospital Inpatients

**Provider Types Affected:** Physicians

**Problem Description:** After a review of Medicare policy and an analysis of data, the Recovery Auditors found a high percentage of errors on Evaluation and Management services (E/M). When E/M services are provided to patients admitted to an inpatient hospital setting, then Current Procedural Terminology (CPT) Codes 99221-99223, 99231-99233, and 99238-99239 are to be used. CPT codes 99201-99215 are to be used for E/M services provided in the physician's office, or in an outpatient or other ambulatory facility.

Most of the improper payments for E/M services are due to incorrect coding and insufficient documentation errors. Incorrect coding errors for E&M services are commonly found when the provider submitted medical documentation that supported a different E/M code than the code billed. These errors correspond to errors reported in the 2011 Comprehensive Error Rate Testing (CERT) report.

**Recovery Auditor Finding:** The following two scenarios exemplify reasons for adjustments the Recovery Auditors make in order to align provider payments with Medicare guidelines.

**Example 1:** An 80-year-old female was admitted to a hospital for inpatient level of care on October 17, 2012, and was discharged on October 20, 2012. A physician billed CPT Code 99205 (Office or other outpatient visit for the evaluation and management of

a new patient) for date of service October 18, 2012. Date of service October 18, 2012, is during the inpatient hospital stay and data analysis confirms that the patient was not on a leave-of-absence from the hospital on that date.

**Finding:** CPT Code 99205 is the overpaid claim.

**Example 2:** A 79-year-old female was admitted to a hospital for inpatient level of care on October 23, 2012, and was discharged on October 26, 2012. A physician billed CPT Code 99205 (Office or other outpatient visit for the evaluation and management of a new patient) for date of service October 24, 2012. Date of service October 24, 2012, is during the inpatient hospital stay and data analysis confirms that the patient was not on a leave-of-absence from the hospital on that date.

**Finding:** CPT Code 99205 is the overpaid claim.

### Guidance: How Providers Can Avoid These Problems

- ✓ For initial hospital care code, a physician must meet three key components for the service: (1) comprehensive history, (2) comprehensive exam, and (3) high complexity medical decision-making.

### Resources:

Additional information can be found in the following manuals/publications:

- Review MLN Matters® Special Edition article SE1010, **Questions and Answers on Reporting Physician Consultation Services**, at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1010.pdf> on the CMS website.
- Review MLN Matters® article MM7405, **Clarification of Evaluation and Management (E/M) Payment Policy** outlines codes to be used for billing for inpatient visits at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7405.pdf> on the CMS website.
- MLN Matters® article MM6740 highlights **Revisions to Consultation Services Payment Policy** and alerts providers that effective January 1, 2010, the Current Procedural Terminology (CPT) consultation codes (ranges 99241-99245 and 99251-99255) are no longer recognized for Medicare Part B payment. You may review this article at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6740.pdf> on the CMS website.

## Recovery Audit Finding: Evaluation and Management Services with Allergy Services

**Provider Types Affected:** Physicians

**Problem Description:** Evaluation and management (E/M) codes reported with allergy testing or allergy immunotherapy are appropriate only if a significant, separately identifiable service is performed. Obtaining informed consent is included in the immunotherapy service and should not be reported with an E/M code. If E/M services are reported, modifier 25 should be utilized. The Recovery Auditors concluded that the services were provided and medically necessary, but the provider billed and the Medicare paid for all or part of them more than once.

**Recovery Auditor Finding:** The following two scenarios exemplify reasons for adjustments the Recovery Auditors make in order to align provider payments with Medicare guidelines.

**Example 1:** On August 23, 2012, a professional bill was submitted with E/M code 99214 and Immunotherapy injections code 95117.

**Finding:** The billing of these two codes without modifier 25 to indicate that a significant, separately identifiable service was performed resulted in an overpayment.

**Example 2:** On October 25, 2012, a professional bill was submitted with E/M code 99213 and Immunotherapy one injection code 95115.

**Finding:** The billing of these two codes without modifier 25 to indicate that a significant, separately identifiable service was performed resulted in an overpayment.

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

According to the CMS' "Medicare Claims Processing Manual" (Chapter 12, Section 200, subsection C), in order for a physician to receive payment for a visit service provided on the same day that the physician also provides a service in the allergen immunotherapy series (i.e., any service in the series from 95115 through 95199), the physician is to bill a modifier 25 with the visit code, indicating that the patient's condition required a significant, separately identifiable visit service above and beyond the allergen immunotherapy service provided. Medical necessity remains the key as typically allergy injections are pre-scheduled and no other services beyond the injection are scheduled. The injection code includes the minimal amount of work needed to make the determination that the patient is fit to undergo the procedure. However if the patient has a significant, separately identifiable problem that meets the requirements of an E/M service, this may be billed using Modifier 25 for claims processing.

Providers may want to focus on E/M services tied to typically scheduled services and pull the documentation

and compare the "visit intent" against the content of the notes. By monitoring the occurrences of E/M services billed in conjunction with scheduled services, billing errors are less likely.

### Resources:

- The "Medicare Claims Processing Manual," Chapter 12, Section 200, Subsection C is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf> on the CMS website.
- The **Evaluation and Management Services Guide** published by CMS 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.
- The Medicare Learning Network® (MLN) Educational Web Guides **Documentation Guidelines for Evaluation and Management (E/M) Services** page offers health care professionals E/M services information and resources. The following E/M publications can be accessed in the "Downloads" Section at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html> on the CMS website.

## Recovery Audit Finding: Source of Admission Code for Inpatient Psychiatric Facilities (IPFs)

**Provider Types Affected:** Outpatient Hospital

**Problem Description:** The Recovery Auditors conducted claim reviews of the Medicare Prospective Payment System (PPS) for Inpatient Psychiatric Facilities (IPFs) and determined that the majority of the time when patients are transferred within the same facility overpayments occur because the Source of Admission Code 'D' is not billed for those claims. Source of Admission Code 'D' is designated for usage when a patient is discharged from an acute hospital to their own psychiatric distinct part unit (DPU). This code will prevent the additional payment for the beneficiary's first day of coverage at the DPU.

Under the Medicare PPS for IPFs, CMS makes an additional payment to an IPF or a DPU for the first day of a beneficiary's stay to account for emergency department costs if the IPF has a qualifying emergency department. However, CMS does not make this payment if the beneficiary was discharged from the acute care section of a hospital to its own hospital based IPF. In that case, the costs of emergency department services are covered by the Medicare payment that the acute hospital received for the beneficiary's inpatient acute stay.

**Recovery Auditor Finding:** The following two scenarios exemplify reasons for adjustments the Recovery Auditors make in order to align provider payments with Medicare guidelines.

**Example 1:** On January 10, 2010, an 85-year-old female is admitted through the Emergency Room for a one day stay in an acute inpatient hospital setting. On January 11, 2010, the patient is admitted to the inpatient psychiatric unit of the same facility. The claim for this admission was submitted with Source of Admission Code "1" (Physician Referral).

**Resolution:** Because the January 11th admission was a transfer from the same facility, the Source of Admission Code should be coded "D". The incorrect Source of Admission Code resulted in an overpayment.

**Example 2:** On January 19, 2012, a 63-year-old male is admitted through the Emergency Room for a two day stay in an acute inpatient hospital setting. On January 21, 2012, the patient is admitted to the inpatient psychiatric unit of the same facility. The claim for this admission was submitted with Source of Admission Code "2" (Clinic Referral).

**Resolution:** Because the January 21st admission was a transfer from the same facility, the Source of Admission Code should be coded "D". The incorrect Source of Admission Code resulted in an overpayment.

### Guidance: How Providers Can Avoid These Problems

- ✓ Alert billing staffs to use Source of Admission Code "D" when transferring a beneficiary from acute care to the psychiatric unit of their facility.

### Resources:

- For more information about IPFs and use of Source of Admission Code D, visit SE1020 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1020.pdf> on the CMS website.
- MLN Matters® article MM3881 provides additional information about Source Code 'D' at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM3881.pdf> on the CMS website.

## Recovery Audit Finding: Metastasis As Secondary Diagnosis MS-DRGs 820-825, 840-842

**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.

The Office of Inspector General (OIG) reported in report OAI-12-88-01010 that in reviewing claims and medical records for Medicare Severity - Diagnosis-Related Groups (MS-DRGs), errors were found in the assignment of DRG's resulting in overpayment to hospitals. The OIG identified that errors in the sample could be traced to the hospital's medical record and admission practices, and an analysis of billing data indicated that a potential aberrant billing practice may exist. Hospitals were incorrectly reporting the principal diagnosis for cases admitted with conditions such as dehydration or anemia, but who also had a documented neoplasm.

Recovery Auditors validated the following MS-DRGs for principal and secondary diagnoses and procedures as affecting or potentially affecting MS-DRG assignment:

- MS-DRG 820 Lymphoma and Leukemia with Major O.R. Procedure with MCC

- MS-DRG 821 Lymphoma and Leukemia with Major O.R. Procedure with CC
- MS-DRG 822 Lymphoma and Leukemia with Major O.R. Procedure without CC/MCC
- MS-DRG 823 Lymphoma and Nonacute Leukemia with Other O.R. Procedure with MCC
- MS-DRG 824 Lymphoma and Nonacute Leukemia with Other O.R. Procedure with CC
- MS-DRG 825 Lymphoma and Nonacute Leukemia with Other O.R. Procedure without CC/MCC
- MS-DRG 840 Lymphoma and Nonacute Leukemia with MCC
- MS-DRG 841 Lymphoma and Nonacute Leukemia with CC
- MS-DRG 842 Lymphoma and Nonacute Leukemia without CC/MCC

**Example 1:** A 77-year-old male with chronic lymphocytic leukemia who had been undergoing chemotherapy was seen because he had been having diarrhea for 3 weeks. It was felt that the diarrhea might be secondary to chemotherapeutically-induced gastroenteritis or infectious gastroenteritis. The patient was admitted to the hospital service with marked dehydration secondary to chronic diarrhea. He was felt to be malnourished, and he was found to be pancytopenic. He was seen in consultation by hematologist, and blood counts

were monitored. He required 2 units of packed red blood cells for anemia. He was also seen in consultation by gastroenterologist. Stool studies were negative, and leukocytes were negative. The patient did not require an endoscopy. He had a normal TSH. Prior to admission he had a negative stool for *Clostridium Difficile* and negative stool cultures. He had no fever, and he had no severe abdominal pain. His main complaint was intractable diarrhea. He was experiencing nausea, and he did vomit in the hospital. He was placed on Zofran and Imodium around the clock and this seemed to make a big difference. The patient's Imodium was decreased and his Zofran was stopped. Upon discharge, he was encouraged to avoid eating raw fruits and vegetables and to refrain from consuming lactose containing foods.

**Finding:** This patient was admitted with dehydration secondary chronic diarrhea due to chemotherapy, and the provider assigned 204.10 (Chronic Lymphoid Leukemia, Without Mention of Having Achieved Remission) as the principal diagnosis. However, this code was not validated as the principal diagnosis. The documentation in the medical record did not support the assignment of 204.10 (Chronic Lymphoid Leukemia, Without Mention of Having Achieved Remission) as the principal diagnosis. The attending physician

stated in the discharge summary, "Patient was admitted with marked dehydration secondary to chronic diarrhea." Per coding guidelines and documentation in the medical record, the main reason for admission was dehydration. Coding Clinic Second Quarter states, "When the admission/encounter is for the management of dehydration due to the malignancy or therapy, or a combination of both, and only the dehydration is being treated (intravenous rehydration), the dehydration is sequenced first, followed by the code(s) for the malignancy."

Therefore, code 204.10 (Chronic Lymphoid Leukemia, Without Mention of Having Achieved Remission) was resequenced as a secondary diagnosis and code 276.51 (Dehydration) was sequenced as the principal diagnosis. This change resulted in a reassignment of the MS-DRG from 840 (Lymphoma & Non-Acute Leukemia with MCC) to MS-DRG 640 (Miscellaneous Disorders of Nutrition, Metabolism and Fluids and Electrolytes with MCC)

**Example 2:** An 88-year-old female with hypertension and chronic lymphocytic leukemia had chemotherapy on 11/08, 12/08, and 01/09. She was followed by her hematologist/oncologist and seen for Procrit for her anemia. She was found to have very low hemoglobin (Hgb) and sent to the Emergency Department (ED) for blood transfusions. The patient was admitted for anemia and thrombocytopenia due to questionable ischemic changes. She was also admitted for monitoring on Telemetry. Cardiac

enzymes x 3 requested. The patient was given one unit of platelets and 2 units of packed red blood cells in the ED. Hematology/oncology was called for consultation. For GI prophylaxis, she received Prilosec and for DVT prophylaxis the patient was encouraged to get out of bed to chair with assistance. The patient's primary care physician was informed of the patient's admission and plans for workup. After 2 units of red blood cells, the patient's Hgb remained stable at approximately 9. Hematology/oncology recommended getting the platelets to 10,000 so she received an additional unit of packed red blood cells and another unit of platelets bringing her platelets up to 22,000 and her Hgb up to 9.4. Hematology/oncology again recommended one additional unit of packed red blood cells and another unit of platelets. The patient was discharged to home after receiving the unit of hemoglobin and platelets and was instructed to follow-up with hematology/oncology and her primary care physician.

**Finding:** This patient was admitted for aplastic anemia due to Chronic Lymphoid Leukemia, and the provider assigned code 204.10 (Chronic Lymphoid Leukemia, Without Mention Of Having Achieved Remission) as the principal diagnosis. The documentation in the medical record identified the reason for admission was due to the aplastic anemia for which the patient received blood products.

Therefore, code 204.10 (Chronic Lymphoid Leukemia, Without Mention Of Having Achieved Remission) was resequenced as

a secondary diagnosis, and code 284.89 (Other Specified Aplastic Anemias) was assigned as the principal diagnosis. This change resulted in a reassignment of the MS-DRG 840 (Lymphoma & Non-acute Leukemia with MCC) to MS-DRG 809 (Major Hematologic Immune Diagnosis Except Sickle Cell Crisis & Coagulation with CC).

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

- ✓ Review the documentation within the medical record and assign codes appropriately based on documentation.
- ✓ Select the Principal Diagnosis and remember that the circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the UHDDS as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
- ✓ Apply guidance in the ICD-9-CM Coding Manual (for dates of service on claim), ICD-9-CM Official Guidelines for Coding and Reporting, and ICD-9-CM Addendums and Coding Clinics.
- ✓ Coding Clinic, Second Quarter 2005, page 9 cites ICD-9-CM Official Guidelines for Coding and Reporting: Chapter 1.C.2.c.3 Neoplasms General Guidelines-Management of dehydration due to malignancy as follows:

"When the admission/encounter is for the management of dehydration due to the malignancy or therapy,

or a combination of both, and only the dehydration is being treated (intravenous rehydration), the dehydration is sequenced first, followed by the code(s) for the malignancy.”

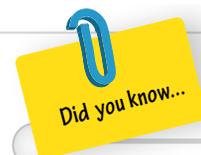
- ✓ Coding Clinic September-October 1984, (8) states:

“Admissions for care and treatment of toxic effects of the drug during the course of chemotherapy should identify the toxic effects as the principal diagnosis with an E code (such as E933.1) to identify the drug. The malignancy should be coded as additional diagnosis.”

#### References:

- The “Medicare Program Integrity Manual” (Chapter 6, Section 6.5.3) states: “The purpose of DRG validation is to ensure that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician’s description and the information contained in the beneficiary’s medical record.” See <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf> on the CMS website).
- The Uniform Hospital Discharge Data Set (UHDDS) Reporting of Inpatient Data Elements, July 31, 1985, Federal Register (Volume 50 No. 147, Pages 31038-31040). This document contains the UHDDS data elements and their definitions that are

used by hospitals to report inpatient data elements in a standardized manner. Since July 31, 1985, the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc.). Note that in determining principal diagnosis, the coding conventions in the International Classification of Diseases, Ninth Revision (ICD-9-CM), Volumes I and II, take precedence over these official coding guidelines. (See Section I.A., Conventions for the ICD-9-CM). The Office of Inspector General (OIG) Report OAI-12-88-01010, “National DRG Validation Study Special Report on Coding Accuracy,” can be found at <http://oig.hhs.gov/oei/reports/oai-12-88-01010.pdf> on the Internet.



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 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.”](#)





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ICN 908950/ October 2013