

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



Official CMS Information for  
Medicare Fee-For-Service Providers

# Medicare Quarterly Provider Compliance Newsletter



**Guidance to Address  
Billing Errors**

**Volume 2, Issue 4 - July 2012**

# Table of Contents

<b>Comprehensive Error Rate Testing (CERT) Finding:</b> Pressure Reducing Support Surface (PRSS) Claims.....	1
<b>Recovery Audit Finding:</b> Endocrine, Nutritional and Metabolic Disorders – Services Provided in a Medically Unnecessary Setting .....	4
<b>Recovery Audit Finding:</b> Acute Inpatient Neurological Disorders – Medically Unnecessary Items or Services Provided in a Medically Unnecessary Setting.....	7
<b>Recovery Audit Finding:</b> Cardiac Arrhythmia and Conduction Disorders with Complications or Comorbidities – Inappropriate Selection of Principal Diagnosis Code .....	10
<b>Recovery Audit Finding:</b> Other Circulatory System Operating Room (O.R.) Procedures: MS-DRG 264 .....	12
<b>Recovery Audit Finding:</b> Pathological Fractures .....	14
<b>Recovery Audit Finding:</b> Urinary Procedures .....	16
<b>Recovery Audit Finding:</b> Gastrointestinal (GI) Disorders .....	18
<b>Recovery Audit Finding:</b> GI Disorders: Other Digestive System Diagnosis with a Major Complication or Comorbidity (MCC) .....	19
<b>Archive of Previously-Issued Newsletters</b>	

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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. In the Tax Relief and Health Care Act of 2006, the U.S. Congress authorized the expansion of the Recovery Audit Program nationwide by January 2010 to further assist the Centers for Medicare & Medicaid Services (CMS) in identifying improper payments. Medicare FFS Recovery Auditors are contractors that assist CMS by performing claim audits on a post-payment basis.

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

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

This issue includes 11 items identified by Recovery Auditors and one item identified by the CERT review contractor. This issue is designed to help FFS providers, suppliers, and their billing staffs understand their claims submission problems and how to avoid certain billing errors and other improper activities, such as failure to submit timely medical record documentation, when dealing with the Medicare FFS program. An archive of previously issued newsletters is also available to providers in case they missed one. This archive 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.

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

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

## Comprehensive Error Rate Testing (CERT) Finding: Pressure Reducing Support Surface (PRSS) Claims

**Provider Types Affected:** Physicians, Providers, and Suppliers of Part B Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

**Background:** The Comprehensive Error Rate Testing (CERT) program reviews of support surfaces claims have consistently yielded high improper payment rates. Based on these findings, CMS conducted a special study of Pressure Reducing Support Surface (PRSS) claims.

The following discussion presents PRSS coverage requirements, the common causes of improper payments for PRSS claims, an example of a PRSS claim error, and steps that providers and suppliers can follow to avoid these errors.

**Pressure Reducing Support Surfaces Requirements:** Medicare provides coverage for PRSSs under its Part B Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) benefit. There are three PRSS groups with different characteristics and benefit coverage requirements:

- ✓ Group 1 PRSSs include pressure pads and mattress overlays that are placed over the standard home or hospital mattresses.
- ✓ Group 2 PRSSs include powered air floatation beds, powered pressure reducing air mattresses, and non-powered advanced pressure reducing mattresses

that can be used either alone or placed over a bed frame.

- ✓ Group 3 PRSSs are complete bed systems, known as air-fluidized beds, which use the circulation of filtered air through silicone beads.<sup>1</sup>

A group 1 support surface is covered if the patient is completely immobile. Otherwise, he or she must have limited mobility or have any stage pressure ulcer on the trunk or pelvis and demonstrate one of the following conditions: impaired nutritional status, incontinence, altered sensory perception, or compromised circulatory status.<sup>2,3,4</sup>

A group 2 support surface is covered if the patient has multiple stage II pressure ulcers on the trunk or pelvis, has been on a comprehensive pressure ulcer treatment program for at least the past month and has ulcers which have worsened or remained the same over the past month. A group 2 support surface is also covered if the patient has large or multiple stage III or IV pressure ulcers on the trunk or pelvis, or if the patient had a recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis and has been on a group 2 or 3 support surface immediately prior to a recent

discharge from a hospital or nursing facility (discharge within the past 30 days).<sup>2,3,4</sup>

A group 3 support surface is covered if the patient has a stage III or stage IV pressure ulcer, is bedridden or chair-bound, would be institutionalized without the group 3 support surface, currently under the close supervision of the patient's treating physician, at least one (1) month of conservative treatment has been administered, a caregiver is available and willing to assist with patient care, a physician directs the home treatment regimen, and reevaluates and recertifies the need for the air-fluidized bed on a monthly basis and all other alternative equipment has been considered and ruled out.<sup>2,3,4</sup>

For any DMEPOS item to be covered by Medicare, including PRSSs, the beneficiary's medical record must contain sufficient documentation of the beneficiary's medical condition to substantiate the necessity for the type and quantity of items ordered and the frequency of use or replacement (if applicable). In addition, suppliers must meet all documentation requirements included in the relevant LCD. Suppliers must maintain a variety of documents

<sup>1</sup> Department of Health and Human Services, Office of Inspector General--Inappropriate Medicare Payments for Pressure Reducing Support Surfaces, August 2009 (<http://oig.hhs.gov/oei/reports/oei-02-07-00420.pdf>)

<sup>2</sup> LCD for Pressure Reducing Support Surfaces - Group 1 (L11563) ([http://www.cms.gov/mcd/viewlcd\\_popup.asp?from=basket&type=lcd&page=viewlmp.asp&lcd\\_id=11563&lcd\\_version=26&contractor\\_id=140#d](http://www.cms.gov/mcd/viewlcd_popup.asp?from=basket&type=lcd&page=viewlmp.asp&lcd_id=11563&lcd_version=26&contractor_id=140#d))

<sup>3</sup> LCD for Pressure Reducing Support Surfaces - Group 2 (L11564) ([http://www.cms.gov/mcd/viewlcd\\_popup.asp?from=basket&type=lcd&page=viewlmp.asp&lcd\\_id=11564&lcd\\_version=25&contractor\\_id=140](http://www.cms.gov/mcd/viewlcd_popup.asp?from=basket&type=lcd&page=viewlmp.asp&lcd_id=11564&lcd_version=25&contractor_id=140))

<sup>4</sup> LCD for Pressure Reducing Support Surfaces - Group 3 (L11580) ([http://www.cms.gov/mcd/viewlcd\\_popup.asp?from=basket&type=lcd&page=viewlmp.asp&lcd\\_id=11580&lcd\\_version=29&contractor\\_id=139](http://www.cms.gov/mcd/viewlcd_popup.asp?from=basket&type=lcd&page=viewlmp.asp&lcd_id=11580&lcd_version=29&contractor_id=139))

that support the beneficiary's need for, and the appropriateness of, the provided PRSS.

There are also additional criteria for the continued coverage of each of the three PRSS groups.

- ✓ Group 1 PRSSs are covered until such time when the coverage criteria for a Group 1 mattress overlay or mattress are not met, in which case the claim will be denied as not medically necessary.<sup>2</sup>
- ✓ Group 2 and Group 3 PRSSs are covered until the pressure ulcer is healed. In the absence of continued healing, documentation in the medical records must show that other features of the patient's treatment plan are being changed to support healing or that the use of a group 2 or group 3 PRSS is medically necessary for wound management.<sup>3,4</sup>

## Common Causes of Errors

### Insufficient Documentation Errors

The majority of improper payments identified for these PRSS claims were due to insufficient documentation errors.

- ✓ Claims are placed into this category when the medical documentation submitted is inadequate to support the billing of the claimed service. In other words, the medical reviewers could not conclude that some of the allowed services were actually provided, provided at the level billed, and/or medically necessary.
- ✓ Claims are also placed into this category when specific documentation that is required as a condition of payment is missing, such as a physician

signature on an order or a form that is required by policy to be completely filled out. Most insufficient documentation errors for the PRSS claims resulted from a missing appropriate source of medical documentation and a missing written order for the item ordered.

### Medical Necessity Errors

A medical necessity error occurs when the PRSS supplier submits adequate documentation for the claim reviewer to make an informed decision that the PRSS item billed was not medically necessary based upon Medicare coverage policies. An example of a medical necessity error is when the medical record showed that the beneficiary did not have a level of immobility that qualified him or her for the PRSS item ordered.

### Example of a PRSS Claim Error

Mr. Jones had multiple skin ulcers on his coccyx and hips of various thicknesses and was ordered an air-fluidized bed by his primary care physician. The submitted medical record showed that Mr. Jones was followed by his physician for his wounds, yet there was no record of a comprehensive evaluation performed within one month prior to the initiation of the ordered air-fluidized bed therapy and weekly wound assessments. In addition, monthly recertifications and evaluations supporting the continued need for the air-fluidized bed (as opposed to a lower-level PRSS) were not submitted. As the submitted medical records were inadequate to support the medical necessity of the PRSS item per the governing Medicare coverage criteria, this claim was scored as an insufficient documentation error.

## Guidance on how providers can avoid PRSS claim errors

There are various ways that providers and suppliers can ensure that Medicare coverage criteria for PRSS items are met. Examples of ways in which providers and suppliers can avoid PRSS claim denials include:

- ✓ Ensuring that the PRSS order is signed by the physician prior to the delivery of the item to the beneficiary.
- ✓ Obtaining a signed and dated Statement of Ordering Physician, which includes information concerning what, if any, criteria listed in the Coverage and Payment Rules section of the PRSS Local Coverage Determination (LCD) the beneficiary meets.
- ✓ Supplying authenticated documentation from the medical record that fully supports the criteria listed in the Coverage and Payment Rules of the LCD and the Statement of Ordering Physician.
- ✓ Providing an authenticated medical record that describes the size, location, and stage of the pressure ulcer(s) that are being treated with PRSS.
- ✓ Recording that the beneficiary has been under a comprehensive pressure ulcer treatment program or under the close supervision of the treating physician for at least one month with conservative treatment being administered and all other alternative equipment has been considered and ruled out (as described in the LCD).

- ✓ Demonstrating that a caregiver is available and willing to assist with the beneficiary's care related to the PRSS item.
- ✓ Documenting that the physician directs the home treatment regimen and reevaluates and recertifies the need for the PRSS item on a monthly basis.

#### Resources:

- ✓ The MLN Matters® Special Article SE1014 "Medicare Policy Regarding Pressure Reducing Support Surfaces," is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1014.pdf> on the CMS website.
- ✓ For more information about Documentation, refer to the "Medicare Program Integrity Manual," Chapter 5, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c05.pdf> on the CMS website.
- ✓ The DME MAC LCDs "Pressure Reducing Support Surface – Group 1," "Pressure Reducing Support Surface – Group 2," and "Pressure Reducing Support Surface – Group 3" can be found by searching "support surfaces" on the Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx> on the CMS website.

- ✓ The OIG report, Inappropriate Payments for Pressure Reducing Support Surfaces OEI-02-07-00420 is available at <http://www.oig.hhs.gov/oei/reports/oei-02-07-00420.pdf> on the Internet.
- ✓ Review the LCD for Pressure Reducing Support Surfaces - Group 1 (L11563), available at [http://www.cms.gov/mcd/viewlcd\\_popup.asp?from=basket&type=lcd&page=view/mrp.asp&lcd\\_id=11563&lcd\\_version=26&contractor\\_id=140#d](http://www.cms.gov/mcd/viewlcd_popup.asp?from=basket&type=lcd&page=view/mrp.asp&lcd_id=11563&lcd_version=26&contractor_id=140#d) on the CMS website.
- ✓ Review the LCD for Pressure Reducing Support Surfaces - Group 2 (L11564), available at [http://www.cms.gov/mcd/viewlcd\\_popup.asp?from=basket&type=lcd&page=view/mrp.asp&lcd\\_id=11564&lcd\\_version=25&contractor\\_id=140](http://www.cms.gov/mcd/viewlcd_popup.asp?from=basket&type=lcd&page=view/mrp.asp&lcd_id=11564&lcd_version=25&contractor_id=140) on the CMS website.

- ✓ Review the LCD for Pressure Reducing Support Surfaces - Group 3 (L11580), available at [http://www.cms.gov/mcd/viewlcd\\_popup.asp?from=basket&type=lcd&page=view/mrp.asp&lcd\\_id=11580&lcd\\_version=29&contractor\\_id=139](http://www.cms.gov/mcd/viewlcd_popup.asp?from=basket&type=lcd&page=view/mrp.asp&lcd_id=11580&lcd_version=29&contractor_id=139) on the CMS website.



Did you know...

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

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

## Recovery Audit Finding: Endocrine, Nutritional and Metabolic Disorders – Services Provided in a Medically Unnecessary Setting

**Provider Types Affected:** Inpatient Hospitals

**Problem Description:** In an effort to expedite reviews on the medically necessary aspects of inpatient hospital claims, CMS pre-approved certain MS-DRGs for medical necessity reviews including DRG 296 (Cardiac arrest, unexplained w MCC) and MS-DRG 640 (Nutritional & misc metabolic disorders w MCC). The following two examples highlight medical necessity reviews that were performed to substantiate the need for inpatient admission versus an outpatient level of care.

**Example 1:** A 67-year-old female presented to the Emergency Department (ED) with complaints of dizziness, weakness, and dyspnea on exertion. She denied chest pain, headache, and chills. She had a history of end stage renal failure on dialysis, diabetes, congestive heart failure with an ejection fraction of 50%, atrial fibrillation, hypertension, and tobacco use. Her blood pressure was 149/98, pulse 82, temperature 97.2, and respiratory rate 18, with an oxygen saturation of 95% on room air. A chest x-ray revealed pulmonary edema, without infectious processes noted. An electrocardiogram indicated normal sinus rhythm rate at 80. Her laboratory values revealed a potassium level of 5.9 (3.5-5.5), BUN 57 (10-20), creatinine 9.1 (0.6-1.2), calcium 9.3 (6-10), WBC 6.7 (4-10), troponin negative, and cardiac enzymes remained within normal ranges.

Her admitting diagnosis was ‘Dizziness and Giddiness’ (MS DRG 640; ICD-9-CM Diagnosis Code 780.4). She was treated with oral Kayexalate (Sodium Polystyrene Sulfonate), and she received dialysis treatment. Her symptoms resolved, and she was subsequently discharged to home.

**Example 2:** A 46-year-old female was transferred from a group home to the hospital due to an increased potassium level. She had a chronic history of elevated potassium and creatinine levels, and she also had a history of Down’s syndrome, chronic kidney disease, diabetes, hypothyroidism, dyslipidemia and seizure disorder. Her blood pressure was 137/69, temperature 97.5, pulse 82, respiratory rate 16, and oxygen saturation 98%. She was not in acute distress, her lungs were clear to auscultation bilaterally, and her heart had a regular rate and rhythm. There was no edema, and laboratory findings revealed sodium 141 (135-150), potassium 5.8 (3.5-5.0), BUN 86 (7-20), and creatinine 3.0 (0.6-1.0). In the ED, the patient received intravenous normal saline, Kayexalate and insulin/D50 concentration. A repeat potassium level revealed a potassium level of 4.8, and her electrocardiogram in the ED revealed a Normal Sinus Rhythm (NSR) with no acute changes.

Her admitting diagnosis was Hyperpotassemia (MS DRG 640; ICD-9-CM Diagnosis Code 276.7).

Upon admission, the physician’s plan included telemetry monitoring, urine electrolytes, renal ultrasound, and HgA1C in the morning.

**Findings:** 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.” The Recovery Auditor determined that the requirements for inpatient status, as outlined in Medicare regulatory documents, were not met by either of these two examples, and each of these two beneficiaries could have been safely evaluated and treated in an outpatient setting.

The Example 1 beneficiary did not meet criteria for inpatient status due to the following:

- ✓ She was an end stage renal disease patient who missed dialysis and is now symptomatic;
- ✓ Her potassium level was only mildly elevated;
- ✓ She was stable, and her symptoms would be expected to resolve after routine dialysis which is an outpatient service; and
- ✓ The use of a brief period of time to determine if a potentially dangerous condition will resolve is defined as outpatient observation services.

The Example 2 beneficiary did not meet criteria for inpatient status due to the following:

- ✓ She had a chronic history of high potassium levels which were routinely monitored and treated;
- ✓ She was asymptomatic, and she was in no acute distress on admission; and
- ✓ She was stable, and the treatment provided would not be expected to require a prolonged stay; and
- ✓ The use of a brief period of time to determine if a potentially dangerous condition will resolve is defined as outpatient observation services.

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

The "Medicare Benefit Policy Manual," (Chapter 6, Section 20.6), states that "observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge."

"When a physician orders that a patient receive observation care, the patient's status is that of an outpatient. The purpose of observation is to determine the need for further treatment or for inpatient

admission. Thus, a patient receiving observation services may improve and be released, or be admitted as an inpatient."

According to the "Medicare Program Integrity Manual," (Chapter 6, Section 6.5.2), when making the decision to admit, the provider should "consider, in his/her review of the medical record, any pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary. Factors that may result in an inconvenience to a beneficiary or family do not, by themselves, justify inpatient admission. When such factors affect the beneficiary's health, consider them in determining whether inpatient hospitalization was appropriate.

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

The "Medicare Benefit Policy Manual," (Chapter 1, Section 10) states that "an inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services."

"The decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting."

Factors to be considered when making the decision to admit include such things as:

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

### 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.
- ✓ The "Medicare Program Integrity Manual," Chapter 13, Sections 13.1, 13.1.1, and 13.1.3 is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf> on the CMS website.
- ✓ 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.

- ✓ The "Medicare Benefit Policy Manual," Chapter 6, Section 20.6, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf> on the CMS website.
- ✓ The Social Security Act (Public Law 98-21) Section 1886(d) is available at [http://www.ssa.gov/OP\\_Home/ssact/title18/1886.htm](http://www.ssa.gov/OP_Home/ssact/title18/1886.htm) on the Internet.
- ✓ The "Medicare Claims Processing Manual," Chapter 3, Section 40.2.2, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf> on the CMS website
- ✓ The "Medicare Claims Processing Manual," Chapter 4, Sections 290.1, and 290.2.2 is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf> on the CMS website.
- ✓ The Office of Inspector General Report A-01-10-01000 July 2010 "Analysis of Errors Identified in Fiscal Year 2009 Comprehensive Error Rate Testing Program" is available at <http://oig.hhs.gov/oas/reports/region1/11001000.pdf> on the Internet.
- ✓ The Office of Inspector General Report 09-88-00880 "National DRG Validation Study Unnecessary Admissions to Hospitals" is available at <http://oig.hhs.gov/oei/reports/oai-09-88-00880.pdf> on the Internet.
- ✓ The OIG Report oai-05-88-00730 "National DRG Validation Study: Short Hospitalizations" is available at <http://oig.hhs.gov/oei/reports/oai-05-88-00730.pdf> on the Internet.



**Did you know...**

Did the medical records support the service billed on your claim selected by the CERT, Recovery Auditors (RA), or Medicare contractor(s), but you still received an error? Were some of the documents missing from your original response to the documentation request which caused the claim to be in error? If you receive an error on a claim selected by the CERT, RA or Medicare contractor, please review the medical records and determine if you agree with the results. If you disagree, you can appeal with your local Medicare contractor using the normal appeal process. Visit your local Medicare contractor's website for any appeal forms and appeal process. To find your local Medicare contractors contact information and website address, please visit <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip> on the CMS website. For more information about the Medicare Part A and Part B administrative appeals process, please refer to the Medicare Learning Network® brochure "The Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers".

## Recovery Audit Finding: Acute Inpatient Neurological Disorders – Medically Unnecessary Items or Services provided in a Medically Unnecessary Setting

### Provider Types Affected: Inpatient Hospitals

**Problem Description:** Medicare pays for inpatient hospital services that are medically necessary for the setting billed. Short stay claims billed for neurological disorders under MS-DRGs 068-074, 103, and 312 have been identified for medical record review based on the risk of improper payment for inpatient care when outpatient care was provided. Medical documentation is reviewed to determine that services were medically necessary. The reviews are performed to substantiate the need for inpatient admission versus an outpatient level of care for these patients. The MS-DRGs evaluated were:

- ✓ 068 - (Nonspecified CVA and precerebral occlusion without infarct without MCC);
- ✓ 069 - (transient ischemia);
- ✓ 070 - (Nonspecific cerebrovascular disorders w MCC);
- ✓ 071 - (Nonspecific cerebrovascular disorders w CC);
- ✓ 072 - (Nonspecific cerebrovascular disorders w/o CC/MCC);
- ✓ 073 - (Cranial & peripheral nerve disorders w MCC);
- ✓ 074 - (Cranial & peripheral nerve disorders w/o MCC);
- ✓ 103 - (Headaches without MCC); and
- ✓ 312 - (Syncope & collapse).

Listed below are two examples of medical necessity reviews that highlight improperly billed services related to acute inpatient neurological disorders.

**Example 1:** A 70-year-old male, with a history of an inferior myocardial infarction in August 2010, experienced recurring chest pain in November with an angiogram negative for reversible ischemia with medical management. On December 18, 2010, he awoke with chest pain, took multiple doses of nitroglycerin, and subsequently suffered a syncopal episode. He was taken to the ED by ambulance where his chest pain was relieved. According to family members, the patient woke up with chest pain. His chest pain was retrosternal and radiating to his back. He was taking multiple doses of nitroglycerin which did not completely resolve his pain. He was leaning against a building and suddenly had a syncopal episode. It was unwitnessed, therefore, it is unclear how long it lasted. The patient had no chest pain. With the chest pain, he felt nauseous but did not have any diaphoresis. He had not had any cough or fever.

His physical exam revealed a well-developed, well-nourished male who appeared very comfortable in no distress; S1, S2 was regular; and within normal limits; Neurologic: grossly nonfocal. Conversation through his family was appropriate, and he was using all extremities symmetrically. It was felt that other possible reasons for his syncope might be low blood

sugar and possibly even terazosin which he was recently started on. The patient was a full code.

He was admitted on December 18, 2010, for telemetry and evaluation. He was placed on LovenoX because of his prior history of heart disease and risk factors. On admission, his blood pressure was 106/74, heart rate 80 and regular, and respiratory rate 21. He was afebrile, and his oxygen saturation was 97% on room air. His physical exam was otherwise unremarkable. His electrocardiogram (EKG) was unchanged from previously with no acute changes. There were no



arrhythmias, and his enzymes were negative. His admitting diagnosis was ICD-9-CM diagnosis code 780.2 (Syncope and Collapse).

He did not have any ongoing chest pain. A cardiology consult saw the patient and felt that the patient had a syncopal episode secondary to nitroglycerin, as the patient took nitroglycerin, stood up, felt dizzy, and had syncope. He was instructed not to immediately stand up after he takes nitroglycerin. His blood pressure remained normal, and he is asymptomatic. His chronic renal failure was stable. The patient was discharged to home in stable condition on December 19, 2010, with instructions not to rise immediately after taking nitroglycerin. Follow up appointments were made with the Primary Care Provider in 3-5 days and the Cardiologist in 1-2 weeks. The patient's discharge diagnosis was 1) Syncope secondary to nitroglycerin and hypotension; 2) History of coronary artery disease; and 3) Chronic renal failure. Hospital billed MS-DRG 312 (Syncope/Collapse).

**Findings:** The Recovery Audit determined that the services provided could have been performed in an outpatient/ observation setting. The purpose of observation is to determine whether the patient should be admitted as an inpatient or can safely be sent home.

The statutory authority for the Medical Review program includes the following sections of the Social Security Act (the Act):

- ✓ Section 1862(a)(1)(A) which states no Medicare payment shall be made for expenses incurred

for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member;"

- ✓ Section 1833(e) which states, in part "...no payment shall be made to any provider... unless there has been furnished such information as may be necessary in order to determine the amounts due such provider ..."

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

The "Medicare Benefit Policy Manual," (Chapter 1, Section 10) states that "an inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services."

"The decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting."

"Factors to be considered when making the decision to admit include such things as:

- ✓ The severity of the signs and symptoms exhibited by the patient;
- ✓ The medical predictability of something adverse happening to the patient;

- ✓ The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- ✓ The availability of diagnostic procedures at the time when and at the location where the patient presents."

According to the "Medicare Program Integrity Manual," (Chapter 6, Section 6.5.2) when making the decision to admit, the provider should "consider, in his/her review of the medical record, any pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary. Factors that may result in an inconvenience to a beneficiary or family do not, by themselves, justify inpatient admission. When such factors affect the beneficiary's health, consider them in determining whether inpatient hospitalization was appropriate."

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

The "Medicare Benefit Policy Manual," (Chapter 1 (Inpatient Hospital Services Covered Under Part A), Section 10 (Covered Inpatient Hospital Services Covered Under Part A - Minor Surgery or Other Treatment) states that "when patients with known diagnoses enter a hospital for a specific minor surgical procedure

or other treatment that is expected to keep them in the hospital for only a few hours (less than 24), they are considered outpatients for coverage purposes regardless of: the hour they came to the hospital, whether they used a bed, and whether they remained in the hospital past midnight.”

#### Resources:

- ✓ 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.
- ✓ The "Medicare Benefit Policy Manual," Chapter 6, Section 10 is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.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.
- ✓ The "Medicare Program Integrity Manual," Chapter 13, Sections 13.1, Section 13.1.1, and Section 13.1.3 is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf> on the CMS website.

- ✓ MLN Matters® Article SE1037 "Guidance on Hospital Inpatient Admission Decisions" is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1037.pdf> on the CMS website.
- ✓ The "Medicare Claims Processing Manual," Chapter 12, Section 30.6.8 is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf> on the CMS website.



Did you know...

Looking for the latest new and revised MLN Matters® articles? The Medicare Learning Network® offers several ways to search and quickly find articles of interest to you:

- **MLN Matters® Search Engine:** an advanced search feature that allows you to search MLN Matters® articles from 2004 to the current year.
- **MLN Matters® Index:** a list of common keywords and phrases contained within MLN Matters® articles. Each index is organized by year with the ability to search by specific keywords and topics. Most indices link directly to the related article(s). For a list of available indices, visit the **MLN Matters® Articles web page** and scroll down to the 'Downloads' section.

## Recovery Audit Finding: Cardiac Arrhythmia and Conduction Disorders with Complications or Comorbidities – Inappropriate Selection of Principal Diagnosis Code

### Provider Types Affected: Inpatient Hospitals

**Problem Description:** The purpose of Medicare Severity - Diagnosis Related Group (MS-DRG) Validation is to determine that the principal diagnosis, procedures and all secondary diagnoses identified as Complications or Comorbidities (CCs) and Major Complications or Comorbidities (MCCs) are actually present, correctly sequenced, coded, and clinically validated. When a patient is admitted to the hospital, the condition established after study found to be chiefly responsible for occasioning the admission to the hospital should be sequenced as the principal diagnosis. The other diagnosis identified should represent all (MCC/CC) present during the admission that impact the stay. The Present on Admission (POA) indicator for all diagnoses reported must be coded correctly. Reviewers will validate for MS DRG 308 (Cardiac arrhythmia and conduction disorders with MCC) and/or 309 (Cardiac arrhythmia & conduction disorders w CC), principal diagnosis, secondary diagnoses, and procedures affecting or potentially affecting the DRG.

These MS-DRGs were selected for validation because previous improper payments have been found by the Centers for Medicare & Medicaid Services (CMS) Top Volume DRGs, Office of Inspector General (OIG), Program for Evaluating Payment Patterns Electronic Report (PEPPER) reports Target Area data for 2 day stays for cardiac arrhythmias.

**Example 1:** An 87-year-old female was admitted through the ED with shortness of breath. In the ED it was noted that the patient was in CHF with an elevated Brain Natriuretic Peptide (BNP). The patient was admitted for diuresis with an admitting diagnosis of “Shortness of breath.” She had a history of atrial fibrillation and ablation. The patient said that she had not been taking her prescribed Lasix at home. The history and physical impression was CHF. The patient was given IV Lasix during her hospitalization and quickly returned to baseline. An EKG test performed on the patient was read by the computer as atrial fibrillation and read by the physician as in normal sinus rhythm. Final diagnosis on discharge was mild systolic and diastolic congestive heart failure and recent arrhythmia - atrial fibrillation.

**Finding:** Inappropriate selection of the principal diagnosis.

Although many similar patients are candidates for observation, in this particular case the details of the medical record supported an inpatient determination so the case was not selected on that basis. The case is displayed because the selection of the principal diagnosis was also incorrect. In this case, the principal diagnosis was changed from ICD-9-CM Diagnosis Code 427.31 (Atrial Fibrillation) to ICD-9-CM Diagnosis Code 428.43 (Acute or Chronic Systolic/Diastolic Heart Failure) based on medical documentation. This change caused a change from MS-DRG 308

(Cardiac Arrhythmia and Conduction Disorders with MCC) to MS-DRG 293 (Heart Failure and Shock without CC/MCC).

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

It is important to follow the official coding guidelines for selection of principal diagnosis. 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. Other identified diagnoses should represent all conditions, including any MCCs and CCs present during the admission that affect the hospital stay. In accordance with the Uniform Hospital Discharge Data Set (UHDDS) item #11-b, other (secondary) diagnoses is defined as “all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.” Note that the present on admission (POA) indicator for all diagnoses reported (both principal and secondary) must also be coded correctly.

**Resources:**

- ✓ The “Medicare Program Integrity Manual,” Chapter 6, Section 6.5.3A - C is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf> on the CMS website;
- ✓ The MLN fact sheet titled “Present on Admission (POA) Indicator Reporting by Acute Inpatient Prospective Payment System (IPPS) Hospitals” clarifies how to apply POA indicators to diagnosis codes for certain healthcare claims. This fact sheet is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/wPOAFactSheet.pdf> on the CMS website.
- ✓ The “ICD-9-CM Official Guidelines for Coding and Reporting,” Section II – Selection of Principal Diagnosis, is available at [http://www.cdc.gov/nchs/data/icd9/icd9cm\\_guidelines\\_2011.pdf](http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf) on the Internet.

Did you know...

The condition chiefly responsible for a patient’s admission to the hospital should be sequenced as the principal diagnosis. Code only those conditions documented by the physician. Refer to the Medicare Learning Network (MLN)® fact sheet "[Present on Admission \(POA\) Indicator Reporting by Acute Inpatient Prospective Payment System \(IPPS\) Hospitals](#)" for more information.



## Recovery Audit Finding: Other Circulatory System Operating Room (O.R.) Procedures: MS-DRG 264

**Provider Types Affected:** Inpatient Hospitals

**Problem Description:** Diagnostic Related Group (DRG) validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, match both the attending physician description and the information contained in the beneficiary's medical record. Reviewers validated for Medicare Severity-DRG (MS-DRG) 264 (Other Circulatory System O.R. Procedures), previously DRG 120, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG.

**Example 1:** The patient is an 83-year-old female admitted with a gangrenous great toe and an open wound on the right foot. Her admitting diagnoses are: 1. Toe Gangrene 2. Hypertension 3. Coronary Artery Disease (CAD) 4. Hyperlipidemia.

The history and physical states that she is complaining of right foot gangrene. The patient has been hospitalized for approximately 5 months at another facility for renal failure, toe amputation, and cholecystectomy. The patient also reportedly lost 100 pounds over the past 5 months, and has had watery diarrhea for the past 24 hours. Prior Medical History: diabetes, hypertension, End Stage Renal Disease (ESRD), Myocardial Infarction (MI) with stent, hyperlipidemia. Review of Systems: no reports of fever, chills, joint pain or stiffness. Positive for easy bruising.

**Physical Examination:** Vital signs: blood pressure 129/73, pulse 77, respirations 18, temperature 96.9, oxygen saturation 98% room air. No apparent distress, EKG shows atrial fibrillation with controlled ventricular rate. Right foot, 4th toe amputated, third toe gangrene with open wound with serosanguinous drainage.

The operative note states gangrenous changes of distal right third toe eschar debrided. Flexor tendons visible and portion excised. Excisional debridement of necrotic tissue down through tendons using sharp dissection.

**The discharge summary states that the discharge diagnoses are:**

1. Gangrene third toe
2. UTI
3. Hypertension
4. ESRD
5. Hyperparathyroidism
6. Hypokalemia
7. Anemia
8. Hyperlipidemia
9. CAD
10. MI.

83 year old female with right third toe gangrene, who was admitted to the hospital for Intravenous Levaquin, surgical wound debridement. Patient had renal ultrasound, which revealed echogenic kidneys consistent with medical kidney disease. Patient's chest x-ray revealed no failure. Patient had cardiology and nephology consults which revealed stable chronic disease. Patient had wound care and physical therapy and rehabilitation consult and was discharged to nursing home with oral Levaquin.

**Finding:** Procedure code 86.22 (excisional debridement) is replaced with 83.39 (excision of lesion of other soft tissue) as is supported by the documentation submitted. The excisional debridement in this case

went down to the tendon and, per ICD-9-CM Index and Coding Clinic 2005 Q2 Page 3, codes should be assigned for the deepest level of debridement. This results in a change from MS-DRG 264 Other Circulatory System O.R. Procedures to MS-DRG 987 Non-extensive O.R. Procedure Unrelated to PDX w/ MCC. An overpayment is noted.

**Example 2:** The patient is a 91-year-old female admitted with chest pain and shortness of breath, lower extremity edema. She was found to have a non-ST segment elevation myocardial infarction. Patient described the chest pain as substernal chest pain that did not radiate. Patient reported having the chest pain for 1 week, shortness of breath and leg edema for 2 months. Patient was seen the night before in the emergency department, with normal evaluation and labs, and was discharged back to nursing home. Her admitting diagnoses are: 1. Non ST Elevation Myocardial Infarction/ Acute Coronary Syndrome 2. Hypertension 3. Congestive Heart Failure 4. Insulin Dependent Diabetes Mellitus.

Past medical history includes Congestive Heart Failure (CHF), cardiomyopathy, hypertension, and chronic kidney disease, insulin dependent diabetes mellitus, obesity, venous stasis ulcers of the legs.

**Physical Examination:** blood pressure 159/91, pulse 108, respirations 18, temperature 97.7, oxygen saturation 98% room air. No apparent distress, chest - wheezing with cough, CV- HRRR S1 and S2

heard. Skin- Bilateral lower extremity venous stasis ulcers. EKG - Sinus tachycardia with low voltage, T- wave inversions inferior leads, Chest X-ray - cardiomegaly, patchy density.

There is no operative report. Excisional debridement was not documented by the attending physician. Wound care nurse performed cleansing with normal saline and dressing changes to the venous stasis ulcers on the bilateral lower extremities during the hospitalization. The patient had aloe vera ointment placed and hydrocolloid dressing, and pressure reduction mattress was ordered by the wound care nurse.

91-year-old female with Non-ST Elevation Myocardial Infarction (NSTEMI). Patient had elevated Pro-BNP and positive Troponin I. The night before, she had a normal Troponin I. Patient was admitted for conservative management of MI, with heparin, lisinopril, aspirin, plavix, and metoprolol. Patient was also diuresed due the CHF symptoms. Patient was discharged back to the nursing home, with new medications of metoprolol, aspirin, lisinopril and plavix.

**Discharge summary: Diagnoses**

1. NSTEMI
2. Severe cardiomegaly
3. CHF
4. Chronic Kidney Disease
5. Dyslipidemia
6. Diabetes Mellitus
7. Hypertension
8. Obesity
9. Osteoarthritis.

**Finding:** Procedure code 86.22 (Excisional debridement of wound) is deleted as it was not documented or performed during this admission. The DRG is changed from MS-DRG 264 (Other Circulatory System O.R. Procedures) to MS-DRG 280 (Acute myocardial infarction, discharged alive with CC). Overpayment is noted.

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

**Example 1 - Review the Entire Record.**

When coding for debridement, the coder should follow the index. If the physician specifies that an excisional debridement was performed, then follow instructions under, Debridement, excisional. If “excisional” is not specified, then follow instructions under Debridement, nonexcisional.

When coding multiple layer excisional debridement of the same site, the coder should assign a code only for the deepest layer of the excisional debridement.

It is important to look at all areas of the medical record to verify that an excisional debridement was performed. On many occasions, the surgical consent written is non-descriptive or general in nature, and may not reflect the true procedure performed. When documentation is not clear, the physician should be requested to add more specific documentation to the medical record.

The surgical consent form or the title of the operative report states “excisional debridement of toe.” However, looking at the actual procedure note, the physician reports going down to the flexor tendon. Coders should follow the chapter specific coding guidelines and all applicable coding clinics.

**Example 2 - Understand the Purpose of Each Section of the Medical Record.**

The coder may have looked at the wound care nursing sheet, which was titled Wound Measurement Key, and mistaken it for wound debridement. The coder may have assumed an excisional debridement was performed, when in fact, nonexcisional debridement and wound care was performed.



## Recovery Audit Finding: Pathological Fractures

### Provider Types Affected: Inpatient Hospitals

**Problem Description:** The purpose of MS-DRG Validation is to determine that the principal diagnosis, procedures and all secondary diagnoses identified as Complications or Comorbidities (CC) and Major Complications or Comorbidities (MCC) are actually present, correctly sequenced, coded, and clinically validated. When a patient is admitted to the hospital, the condition established after study found to be chiefly responsible for occasioning the admission to the hospital should be sequenced as the principal diagnosis. The other diagnoses identified should include all conditions present during the admission that impacted the stay. The Present on Admission (POA) indicator for all diagnoses reported must be coded correctly.

The DRGs related to pathological fractures have been identified by Program for Evaluating Payment Patterns Electronic Reports (PEPPER) data as having potential for error under the target area analysis of Medical DRGs with MCC or CC, and an analysis of provider billing data indicates that a potential aberrant billing practice may exist for these MS-DRGs.

Therefore the following MS-DRGs were selected for validation to determine if the principal, secondary and procedure diagnoses were assigned inappropriately resulting in payment errors to the hospitals:

- ✓ MS-DRG 542 (Pathological fractures and musculoskelet & conn tiss, malig w major MCC);
- ✓ MS-DRG 543 (Pathological fractures and musculoskelet & conn tiss, malig w CC); and
- ✓ MS-DRG 544 (Pathological fractures and musculoskelet & conn tiss, malig w/o CC/MCC).

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

**Example 1:** A 77-year-old female, with a history of uterine cancer metastatic to the right shoulder, was admitted through the Emergency Department (ED) with intractable right shoulder pain that had become progressively worse over the week prior to admission. The initial assessment was metastatic carcinoma to the right shoulder, and she was also noted to have severe Chronic Obstructive Pulmonary Disease (COPD) on chronic oxygen therapy.

After an oncology consult, she was to be continued on her current pain medications, to begin palliative radiation, and possibly begin a long-acting narcotic for continuous pain control. Additionally, she was started on antibiotics for possible pneumonia with leukocytosis, which was ruled out prior to discharge.

Her final diagnoses were joint pain, acute respiratory failure, malignant neoplasm of bladder, metastatic uterine bladder cancer to bone. Her condition deteriorated and inpatient hospice was ordered, however she expired prior to this transfer.

**Auditor Finding:** In this case, the principal diagnosis was changed from 198.5 (Secondary Malignant Neoplasm of Bone) to 338.3 (Neoplasm Related Pain). According to Section 1.C.6.a.5 of the "ICD-9-CM Official Coding Guidelines and Coding Clinics," Second Quarter 2007 p.13-15 and May-June 1984 p.14, "when the reason for the admission or encounter is documented as pain control/management; the code may be assigned as the principal, with the underlying neoplasm reported as an additional diagnosis." (Coding Clinic May-June 1984 is the original publication related to this topic, and Coding Clinic second quarter 2007 is a clarification of pain codes that relates to neoplasm related pain.)

This change in the principal diagnosis caused an MS-DRG change from 542 (Pathological Fractures and Musculoskeletal and Connective Tissue Malignancy with MCC) to 947 (Signs and Symptoms with MCC.)

**Example 2:** An 88-year-old male with stage 4 prostate cancer, recently discharged from the hospital for workup of leg pain which was found to be metastatic bone cancer, began having nausea, vomiting, and abdominal discomfort 2 days prior to the present admission. At admission, he was noted to have marked lethargy, mental status changes, extreme weakness, and significant hyponatremia with a serum sodium level of 125 mEq/L.

History and physician impression was extensive bony metastases, readmitted to the hospital with lethargy, failure to thrive, dehydration, and persistent discomfort of the lower extremities. He was noted to have significant hyponatremia which might be contributing to his lethargy. He was started on intravenous saline for rehydration, oxygen, medication for pain and nausea, and hospice was consulted. Treatment plan on admission was hydration and the patient was started on normal saline. On admission the physician order, clear liquid diet, IV 150cc NS per hour, oxygen therapy at 5L via nasal cannula, Dilaudid 1g IVP q2h prn for severe pain, Zofran 4g IVP q4h for nausea, and hospice was consulted.

**Auditor Findings:** The principal diagnosis was changed from 198.5 (Secondary Malignant Neoplasm of Bone) to 276.1 (Hyponatremia.) According to Section 1.C.2.c.3 of the "ICD-9-CM Official Coding Guidelines," "when the admission/ encounter is for management of dehydration due to the malignancy or the therapy, or a combination of both, and only the dehydration is being treated (intravenous rehydration), the hyponatremia is sequenced first, followed by the code for the malignancy."

This change in principal diagnosis caused an MS-DRG change from 542 (Pathological Fractures and Musculoskeletal and Connective Tissue Malignancy with MCC) to 641 (Nutritional and Miscellaneous Metabolic Disorders without MCC.)

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

The overall finding in this review was improper sequencing of the principal diagnosis.

- ✓ In both examples, an inappropriate code was selected for the principal diagnosis based on chapter specific coding guidelines and clarifications published within the Coding Clinic.
- ✓ Providers should ensure that coders follow the chapter specific coding guidelines and all applicable coding clinics.

### Resources:

- ✓ The "ICD-9-CM Official Guidelines for Coding and Reporting," Section II – Selection of Principal Diagnosis, is available at [http://www.cdc.gov/nchs/data/icd9/icd9cm\\_guidelines\\_2011.pdf](http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf) on the Internet.
- ✓ The ICD-9-CM Official Coding Guidelines is available at [http://www.ama-assn.org/resources/doc/cpt/icd9cm\\_coding\\_guidelines\\_08-09\\_sm.pdf](http://www.ama-assn.org/resources/doc/cpt/icd9cm_coding_guidelines_08-09_sm.pdf) on the Internet.
- ✓ The "ICD-9 CM for Hospitals," Volumes 1, 2, and 3; "Guidelines for Coding and Reporting," and "ICD-9-CM Addendums and Coding Clinics" (2007-2009), is available at <http://www.cdc.gov/nchs/data/icd9/icdguide10.pdf> on the Centers for Disease Control and Prevention (CDC) website.

- ✓ The "Medicare Program Integrity Manual," Chapter 6, Section 6.5.3, discusses the DRG validation process and some coding requirements. That chapter of the manual is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c06.pdf> on the CMS website.
- ✓ The MLN fact sheet entitled "Present on Admission (POA) Indicator Reporting by Acute Inpatient Prospective Payment System (IPPS) Hospitals" clarifies how to apply POA indicators to diagnosis codes for certain healthcare claims. This fact sheet is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/wPOAFactSheet.pdf> on the CMS website.
- ✓ The OIG Report OEI-01-98-00420 titled "Subject Monitoring the Accuracy of Hospital Coding" (OEI-01-98-00420) is available at <http://oig.hhs.gov/oei/reports/oei-01-98-00420.pdf> on the Internet.

## Recovery Audit Finding: Urinary Procedures

### Provider Types Affected: Inpatient Hospitals

**Problem Description:** The purpose of MS-DRG Validation is to determine that the principal diagnosis, procedures and all secondary diagnoses identified as Complications or Comorbidities (CC) and Major Complications or Comorbidities (MCC) are actually present, correctly sequenced, coded, and clinically validated. When a patient is admitted to the hospital, the condition established after study found to be chiefly responsible for occasioning the admission to the hospital should be sequenced as the principal diagnosis. The other diagnoses identified should include all conditions present during the admission that impacted the stay. The Present on Admission (POA) indicator for all diagnoses reported must be coded correctly.

CMS identified procedures as being among top volume DRGs that had potential for error. The following urinary procedure-related MS-DRGs were selected for review to assure that the diagnoses and procedures were appropriately assigned based on the Program for Evaluating Payment Patterns Electronic Reports (PEPPER) National Target Area Summary for Medical DRGs with CC or MCC:

- ✓ 56.0 - transurethral removal of obstruction from ureter and renal pelvis;
- ✓ 59.8 - Urethral catheterization;
- ✓ V56.0 - Encounter for Dialysis and Dialysis Catheter Care, Extracorporeal Dialysis; and

- ✓ 584.9 - Acute Kidney Failure, unspecified.

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

**Example 1:** A 71-year-old male was admitted through the Emergency Department (ED) with a several day history of increasingly severe left sided flank and abdominal pain. A CT scan of the abdomen performed in the ED confirmed the presence of a 17 millimeter stone in the left ureteropelvic junction causing moderate obstruction. He was admitted with the diagnosis of severe left-sided flank and abdominal pain, for pain management and probable cystoscopy and left ureteral stent placement.

The patient was taken to the operating room. A cystoscopy, left retrograde pyelogram, retrograde stone manipulation was performed, but the stone was left in place and not removed. There was also placement of a ureteral stent performed. He was discharged home on the same day of admission with a plan to follow-up with his physician and to make arrangements for outpatient left extracorporeal shockwave lithotripsy.

**Auditor Finding:** Based upon the documentation in the record, the recovery auditor determined that the coder had selected an incorrect procedure code (ICD-9-CM Procedure Code 56.0 - transurethral removal of obstruction from ureter and renal pelvis). Following the ICD-9-CM Coding Handbook alphabetic Index guidance, the correct code should have been 59.8 (Ureteral

catheterization), to which it was changed.

This change resulted in an MS-DRG change from 669 (Transurethral Procedures w CC) to 694 (Urinary Stones w/o ESW Lithotripsy w/o MCC).

**Example 2:** A 48-year-old female with history of type 2 Diabetes presented with worsening renal failure manifested by elevated BUN and creatinine levels. The plan on admission was to initiate dialysis and a workup for acute kidney injury. Following nephrology consultation, the patient underwent Laparoscopic Chronic Ambulatory Peritoneal Dialysis Catheter Insertion followed by dialysis. She was discharged to continue dialysis as an outpatient, with a principal discharge diagnosis of end-stage renal disease secondary to Diabetes, and secondary diagnoses of hypertension, history of anemia of chronic kidney disease, and renal osteodystrophy.

**Auditor Findings:** The incorrect code was selected for the principal diagnosis. Code V56.0 (Encounter for Dialysis and Dialysis Catheter Care, Extracorporeal Dialysis) should not have been used for the principal diagnosis, because (per Section 1.c.18.d.7 of the Official Coding guidelines) an aftercare V code should not be used if treatment is directed at a current acute disease or injury. Further, the Coding Clinic (1st quarter 2004) states that the use of code V56.0 is used when the patient is seen solely for routine dialysis treatment. The principal diagnosis should have been 250.40 (Diabetes mellitus with renal

manifestation, type II or unspecified type, not stated as uncontrolled), followed by code 583.81 (Nephritis and nephropathy, not specified as acute or chronic, in diseases classified elsewhere). Codes 403.91 (Hypertensive chronic kidney disease) and 585.6 (End stage renal disease) should also be reported as secondary diagnoses.

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

The main issues identified in this recovery audit were incorrect selection of procedure codes, inappropriate selection of principal diagnosis codes, and incorrect coding of secondary diagnoses. Findings associated with inappropriate sequencing of principal diagnosis were identified as selecting the incorrect diagnosis to use as the principal diagnosis when specific coding guidelines are in place; and findings associated with incorrect coding of secondary diagnoses was identified as incorrect selection of the diagnosis code based on the documentation and adding a diagnosis code that was not supported by the documentation. Providers should ensure that the coding accurately captures the documentation in the medical record. Specifically, coders need to follow official coding guidelines, and to complete a thorough review of the medical record when selecting a code.

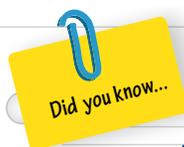
- ✓ In Example 1, the coder used a procedure code that included removal of the kidney stone but the procedure performed only manipulated the stone and the stone was actually left in place. This use of an incorrect code resulted in an overpayment.

- ✓ In Example 2, the coder incorrectly used an aftercare V code for the principal diagnosis, resulting in an underpayment.

### Resources:

- ✓ The “ICD-9-CM Official Guidelines for Coding and Reporting,” Section II – Selection of Principal Diagnosis, is available at [http://www.cdc.gov/nchs/data/icd9/icd9cm\\_guidelines\\_2011.pdf](http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf) on the Internet.
- ✓ Coding Clinic for ICD-9-CM 2nd Quarter 2001 (Vol. 18, No. 2) pp. 12–13 (Renal Dialysis Status), Clarification 2004 1st Quarter p. 22.
- ✓ The “Medicare Program Integrity Manual,” Chapter 6, Section 6.5.3, discusses the DRG validation process and some coding requirements. The manual is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c06.pdf> on the CMS website.

- ✓ The OIG Report OEI-01-98-00420 titled “Subject Monitoring the Accuracy of Hospital Coding” (OEI-01-98-00420) is available at <http://oig.hhs.gov/oei/reports/oei-01-98-00420.pdf> on the Internet.
- ✓ The “ICD-9 CM for Hospitals,” Volumes 1, 2, and 3; “Guidelines for Coding and Reporting,” and “ICD-9-CM Addendums and Coding Clinics” (2007-2009), is available at <http://www.cdc.gov/nchs/data/icd9/icdguide10.pdf> on the Centers for Disease Control and Prevention (CDC) website.



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

## Recovery Audit Finding: Gastrointestinal (GI) Disorders

**Provider Types Affected:** Inpatient Hospitals

**Problem Description:** The Office of Inspector General (OIG), Recovery Audit Contractor (RAC) Demonstration Project (March 2005 through March 2008) and the Medicare CERT review contractor (2007 and 2008) found errors in assignment of Gastrointestinal Tract Disorder-related Diagnostic Related Groups (DRG) that currently map to Medicare Severity-DRGs (MS-DRG) 368, 369, 370, 374, 375, 376, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 392, 393, 394, and 395 (See the list of these MS-DRGs and associated labels in the Resources section of this issue).

These findings resulted in erroneous payments to hospitals. Of 483 records reviewed, 41 were found to have errors. There were 37 cases with errors leading to overpayments and 4 cases with errors leading to underpayments.

Errors in the samples could be traced to the hospitals' medical record practices. An analysis of the billing data indicated that a potential aberrant billing practice may exist for these MS-DRGs.

### Example 1: Dysphagia

The following case in Example 1 is representative of overpayment based on incorrect coding. The provider coded a previous diagnosis as a current diagnosis. This admission is from August 28 to August 29. In this case, MS-DRG 391 (Esophagitis, Gastroenteritis and Misc. Digestive Disorders with MCC) was billed, using secondary diagnosis code 507.0 (Pneumonitis due to inhalation of food and vomitus). Review of

the medical record documentation does not support the assignment of diagnosis code 507.0 as a secondary diagnosis code since it was not present during the admission. The Consultation, History and Physical and Discharge Summary state that the patient had a "recent history of aspiration pneumonia" in a previous admission in early July. In this admission, no antibiotics were given for pneumonia and there were no chest x-ray findings. The Discharge Summary lists "recent aspiration pneumonia" as an additional diagnosis. There is no documentation of pneumonitis occurring during this stay.

The Uniform Hospital Discharge Data Set (UHDDS) Guidelines for reporting other additional diagnoses, Item #11-b, defines other diagnoses as:

"All conditions that co-exist at the time of admission, that develop subsequently, or that affect the treatment received or the length of

stay. Diagnoses that relate to an earlier episode which has no bearing on the current hospital stay are to be excluded."

Therefore, the deletion of the secondary diagnosis code 507.0 results in a MS-DRG change from MS-DRG 391 to MS-DRG 392 (Esophagitis, Gastroenteritis, and Misc. Digestive Disorders without MCC).

**Finding:** The provider incorrectly interpreted the Coding Guidelines regarding secondary diagnoses.

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

Providers should review Official Coding Guidelines, Section III – A, which explains coding for "previous conditions."

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: GI Disorders: Other Digestive System Diagnosis with a Major Complication or Comorbidity (MCC)

**Provider Types Affected:** Inpatient Hospitals

### Medicare Severity-Diagnosis Related Groups (MS-DRG) Validation and Medical Necessity

**Review:** In order for a medical necessity review to be completed, the Recovery Auditor performed complex review of the medical record/ documentation. This review was completed by a licensed clinician, such as a nurse, therapist or physician.

**Problem Description:** The Recovery Auditor conducted a review of records with the DRG 393 (Other Digestive System Diagnosis with a major complication or comorbidity (MCC)). There were improper admissions, resulting in demands for overpayments.

Here are two examples of their findings:

#### Example 1: Inguinal Hernia

The medical record showed that a 79-year-old male was brought to the Emergency Department on the evening of September 28, for increased swelling and redness in scrotal area due to a unilateral inguinal hernia he has had for some time. The patient has a history of right groin hernia, Parkinson's, narcolepsy, and recurring Urinary Tract Infections (UTI). Vital signs: blood pressure 115/58, pulse 64, respirations 20, temperature 98, oxygen saturation 98% on room air. Laboratory results: white blood count normal at 5.9, creatinine 1.30, Prostate-Specific Antigen (PSA) 0.55. There was some swelling and redness in the scrotum last evening. All other systems negative. No acute distress.

Surgery consultation for hernia repair and physical therapy evaluation were done. The surgical consultant noted that the right inguinal hernia has been present for some time but is enlarging and indirect, able to reduce easily. The surgeon discussed with family the option of elective outpatient repair, since there is no indication for urgent surgery. The physical therapy evaluation suggested skilled facility short term for functional mobility training.

The patient was discharged to a Skilled Nursing Facility September 29. The discharge summary states: Right groin hernia easily reducible, non-incarcerated. Plan of care: hydrate for acute renal failure due to creatinine, start Flomax due to PSA, and start Macrobid for recurrent UTI's.

**Finding:** The signs and symptoms documented were not significant or severe enough to warrant the need for medical care on an inpatient

basis and could have been medically evaluated in an observation setting.

#### Example 2: Malfunctioning Device with Bleeding

The medical record shows that a 46-year-old female, disabled due to left above knee amputation and right partial foot amputation, came to the Emergency Department late on August 21, due to bleeding at the colostomy site. The patient said that there had been hemorrhage in the ostomy bag over several hours; she had evacuated clots. Patient history is quite reliable, active bleeding at ostomy site similar to episodes two times in the past. Vital signs stable, no further bleeding, other systems negative.

History of End Stage Renal Disease (ESRD), Deep Vein Thrombosis (DVT), Acute Respiratory Distress (ARD), Coronary Artery By-pass Graft (CABG), right arm DVT. Decubitus ulcer. Colostomy temporary to assist with healing of decubitus ulcer.



In the Emergency Department, manual pressure was applied. Then a crisscross nylon suture was put in place, which produced excellent hemorrhage control. Admitted August 22, for further management and treatment. Vital signs stable, no further bleeding, other systems negative. Nephrology consult: dialysis Tues., Thurs., and Sat., dialyzed previous day, went well. Bleeding may be due to Coumadin coagulopathy. Review of systems negative. No urgent need for dialysis today. Procrit with dialysis for anemia continued.

Surgery consult – stage IV decubitus improving, down to 2cm. No need for further intervention at this time. Continue Coumadin.

Hematology consult - Prothrombin Time and International Normalized Ratio (PT-INR) 1.8 adequate. Epogen continued for anemia secondary to chronic renal failure. Patient discharged home August 23.

**Finding:** The signs and symptoms documented could have been medically evaluated in an observation setting if the physician documented concerns that were not resolved by the end of the ER visit, such as a concern over a possible coagulopathy.

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

It is important for hospitals to ensure that beneficiaries are admitted as inpatients only when they are truly in need of acute inpatient services. The Social Security Act requires that services furnished to Medicare beneficiaries are provided as economically as possible.

- ✓ In order for an in-patient hospital stay to be covered by Medicare, the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay.
- ✓ The beneficiary must demonstrate signs and symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.
- ✓ The hospital may consider any pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary. Factors that may result in an inconvenience to a beneficiary or family do not, by themselves, justify inpatient admission. When such factors affect the beneficiary's health, the reviewer will consider them in determining whether inpatient hospitalization was appropriate.
- ✓ Inpatient care, rather than outpatient care, is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. Without accompanying medical conditions, factors that would only cause the beneficiary inconvenience in terms of time and money needed to care for the beneficiary at home or for travel to a physician's office, or that may cause the beneficiary to worry, do not justify a continued hospital stay.

In these examples, the services were able to be furnished on an outpatient basis in the Emergency Room.

- ✓ In the first example, the patient was not in acute distress and the surgery was not needed immediately. The patient could return for elective outpatient surgery.
- ✓ In the second example, the bleeding at the colostomy site was controlled before the order to admit was written.

### Resources:

- ✓ The "Medicare Benefit Policy Manual," Chapter 1, provides further detail on what constitutes an appropriate inpatient admission. The manual is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf> on the CMS website.
- ✓ All medical necessity reviews were completed in accordance with the "Program Integrity Manual," Chapter 6, Section 6.5, which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf> on the CMS website.



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