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Office of Inspector General Reports Highlight Hospital Billing Issues

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Note: We revised this article to add a link to the Proper Use of Modifiers 59 & –X{EPSU} fact sheet. All other information is the same.

Provider Types Affected

This MLN Matters Article is for hospitals billing Medicare Administrative Contractors (MACs) for services provided to Medicare patients.

Provider Action Needed

In two recent reports, the Office of Inspector General (OIG) cites two significant issues in which hospitals are making coding errors on Medicare claims. Correct coding of claims is important for hospitals to avoid improper payments, which can lead to recoveries of overpayments. CMS encourages hospital billing and coding personnel to review the OIG reports and take steps to avoid the problems identified in those reports. It is important that you support claims submitted by documentation in the patient's medical records.

Background

The OIG reports referenced in this article focused on claims for Right Heart Catheterizations (RHCs) with heart biopsies that used modifier -59 and claims for 96 or more continuous hours of mechanical ventilation.

Improper Use of Modifier -59

In the first report, "Hospitals Nationwide Generally Did Not Comply with Medicare Requirements for Billing Outpatient Right Heart Catheterizations with Heart Biopsies," the OIG analyzed claims to determine if hospitals were correctly reporting modifier -59 for RHCs and heart biopsies. The OIG found that in billing for outpatient RHCs with heart biopsies, hospitals often use modifier -59 inappropriately. This leads to significant overpayments and overpayment recoveries on claims for these services.

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You may want to review the Proper Use of Modifiers 59 & –X{EPSU} fact sheet. You may also want to review CR 8863.

Medicare billing policy allows hospitals to include modifier -59, which indicates that a procedure is separate and distinct from another procedure performed on the same patient on the same day when the procedures performed were separate and distinct. Some hospitals incorrectly billed outpatient RHCs that were performed during the same patient encounter as heart biopsies. By appending modifier -59 to the HCPCS code to claims for RHCs and heart biopsies, some hospitals represented that the RHCs were separate and distinct from the heart biopsies. But we generally intend the payment for a heart biopsy to cover an RHC when you do the RHC during the same encounter.

For example, a hospital billed a procedure with modifier -59 for a patient who received an RHC and a heart biopsy on the same date of service. The medical record documentation didn't support the use of the modifier. As a result, Medicare made an overpayment on the claim. Medicare recovered the overpayment.

Incorrect Procedure Coding for Mechanical Ventilation

In the second report, "Medicare Improperly Paid Hospitals for Beneficiaries Who Had Not Received 96 or More Consecutive Hours of Mechanical Ventilation," the OIG states that hospitals often use incorrect procedure codes when billing for mechanical ventilation. In their study of mechanical ventilation billings, the OIG looked at the relation between Medicare Severity - Diagnosis Related Groups (MS-DRGs) billed to the procedures coded for those DRGs.

Specifically, the OIG looked at the MS-DRG 207 (Respiratory system diagnosis [with] ventilator support 96+ hours) and MS-DRG 870 (Septicemia or severe sepsis [with mechanical ventilation] 96+ hours). The OIG focused on claims where the estimated potential mechanical ventilation procedure length was 4 days or less, based on the date the hospital reported on the claim that mechanical ventilation started. Some hospitals billed MS-DRGs that indicated a stay where they provided 96 or more consecutive hours of mechanical ventilation to the patient, while the estimated potential mechanical ventilation procedure length indicated 4 days or less. Such claims represent overpayments.

In some instances, it appears that coders were likely looking at the number of days in a stay when coding the procedure code for ventilator support. For example, medical record documentation (physician's notes and ventilation records) showed a patient received 68 hours of mechanical ventilation with a stay of 4 days or fewer. However, the claim procedure code showed 96 or more hours of mechanical ventilation were provided. This caused the claim to be grouped to MS-DRG 870 rather than MS-DRG 871. This resulted in a significant overpayment that Medicare recovered from the hospital.

In another example, medical record documentation (ventilation records) showed that a patient was in the hospital for 5 days and received a total of 91 hours of ventilation, but the procedure code on the claim indicated 96 or more consecutive hours of mechanical ventilation was provided. This also resulted in grouping the claim to a MS-DRG that led to a higher and

incorrect payment, which Medicare recovered from the hospital.

More Information

Medicare encourages hospital billing and coding staff to review the Medicare manual sections and other sources noted here to ensure proper billing of ventilation support services and on the proper use of modifier -59. The Medicare Claims Processing Manual, Chapter 3, Inpatient Hospital Billing, Section 10, General Inpatient Requirements.

Providers and billing and coding staff may also want to review the Proper Use of Modifiers 59 & –X{EPSU} fact sheet.

Billing and coding staff may also want to review issues in the Medicare Quarterly Provider Compliance Newsletter, Volume 7, Issue 4.

For more information, find your MAC's website.

Document History

Date of Change	Description
August 29, 2022	We revised the Article to replace or delete web links that no longer worked.
June 7, 2021	We revised this article to add a link to the Proper Use of Modifiers 59 & –X{EPSU} fact sheet. All other information is the same.
September 7, 2017	Initial Article released.