Denials Avoidance & Appeals Management Institute

Case Study B

REVIEW RESULTS LETTER – FINDINGS – OVERPAYMENT

02/06/2014

Medical Records Director
AnyHospital
2129 Medical Necessity Drive
AnyWhere, AL 12345

RE: AnyHospital # 200020
Letter ID: 1234567
Issue: Non-extensive O.R. Procedure Unrelated to Principal Diagnosis MS-DRG's 987, 988, 989 (At this time, Medical Necessity is excluded from review)

Dear Medicare Provider,

The Centers for Medicare & Medicaid Services (CMS) has retained ShowMetheMoney Inc., (SMTM) to carry out the Recovery Audit Contracting (RAC) program in Region Z. The RAC program is mandated by congress and has a primary goal of identifying Medicare improper payments. Improper payments include overpayments and underpayments. Improper payments may occur because of incorrect coding, lack of sufficient documentation or no documentation, use of outdated fee schedule or billing for services that do not meet Medicare's coverage and/or medical necessity criteria etc.

Our request for additional medical documentation, detailed in a letter dated 11/7/2013, constituted reopening under § 1869 (b) (1) (G) of the Social Security Act (the Act) and 42 CFR 405.980 (a) (1). Our good cause to reopen the claim, if required by 42 CFR 405.980 (b) (2) can be found on the SMTM website http://rac.smtm.com.

Detailed information regarding the claim and the findings identified during the review(s) are shown below. Based on the review of the medical documentation for the above referenced claim, SMTM found that some of the services you submitted were not reasonable and necessary as required in § 1862 of the Act. Along with our claims payment determination, we have made limitations on liability decisions for denial of those services subject to provisions of § 1879 the Act. The claim for which we determined that you knew, or should have known, that the services were noncovered have been included in the results of this review. In addition, we have made decisions as to whether or not you are without for the overpayment under the provisions of § 1870 of the Act. The claim for which you are not without fault has been included in the results of this review. Detailed information regarding the claim and the findings identified during the review are shown at the bottom of this letter.

Beneficiary Name/HIC
Claim Reference #/Patient Control #
Audit #
Dates of Service: 1/16/2013 – 1/17/2013
Old DRG: 988

New DRG: 496

Original Diagnosis Codes: 682.7, 272.0, 296.80, 311, 401.9, 412, 996.78, V1271
New Diagnosis Codes: 996.78, 272.0, 296.80, 311, 401.9, 412, 682.7, V1271
Original Procedure Codes: 7868
New Procedure Codes: 7868

Additional Information:

Based on our coding review, the medical documentation does not support the assignment of Cellulitis Foot, except toes code 682.7 as the principal diagnosis. The principal diagnosis is defined in the Uniform Discharge Data Set as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care. The body of the medical record does not support that Cellulitis Foot, except toes meets this definition and instead supports the assignment of Other Complications of Internal Prosthetic Device, Implant and Graft, Due to Other Internal Orthopedic Device, Implant and Graft code 996.78 as the principal diagnosis. This finding is based on Official ICD-9-CM Coding Guidelines state: When the admission is for the treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the 996-999 series and the code lacks the necessary specificity in describing the complication, an additional code for the specific complication should be assigned. Therefore, Cellulitis Foot, except toes code 682.7 will be re-sequenced as a secondary diagnosis, and replaced with Other Complications of Internal Prosthetic Device, Implant and Graft, Due to Other Internal Orthopedic Device, Implant and Graft code 996.78 as the condition meeting the definition of principal diagnosis for this case.

ED MEDICAL NOTES SUMMARY – CLINICAL VIEW

HPI: CC: Infected wound R foot. Pain 10 by numbers. Had surgery with hardware over two years ago, was seen last Friday for same problem, piece of metal visible in open wound. Foot red, swollen and painful. Was given antibiotics for infectyion and did not fill them because of cost. States was running a fever, did not take anything for the fever, states the Ultram he was given made him sick.
ALLERGIES: IODINE
PAST DIAGNOSES: Acute Myocardial Infarction, Bipolar disorder, Gastroesophageal Reflux Disease, Hypercholesterolemia, Hypertension.
SOCIAL HX: Smokes 2 ppd cigarettes

PHYSICAL EXAMINATION:

General: Appears well nourished in no apparent distress.
Skin: Normal color, warm and dry.
Head/Face: Normal
ENT: Normal **Neck:** Normal **Respiratory:** Normal **CV:** Normal **GI:** Normal **Musculoskeletal:** Gait unsteady, Limp right, uses cane. Right Lower Extremity deformity, hardware showing, redness. **Neuro:** A & O X 3
Psychoscocial: Appropriate, calm and cooperative.
MEDICAL NOTES: WBC 12K, XR shows degenerative changes**.** Podiatry wants patient admitted to medicine with plans for procedure in am.

DISPOSITION: Admitted
DIAGNOSIS: Cellulitis/Surgical hardware failure
VITAL SIGNS: BP 136/88, HR 85, RR 18, TEMP 98.3^{0}F
CURRENT MEDS: ASA 500 mg. QD, BP med, Cholesterol med, Lisinopril 5 mg. QD, Plavix po QD, Ranitidine HCL po 150 mg. b.i.d., Trazodone po HS, Ultram po 50 mg. 1-2 prn pain Q 4-6 H, Vicodin po 5/500 1-2 Q6H prn pain.

ED INTERVENTIONS

Wound treatment
Dilaudid 1 mg. IV 16:14
Zofran 4 mg. PO 16:14
NS IV 250 ml/hr
Vancomycin 1 gram IV 18:33
Dilaudid 1 mg. IV 19:01
Patient seen by Podiatrist in ED, removed protruding hardware then cleansed and dressed patient's foot.
20:42
20:45 Admission, Diagnosis: Cellulitis

HISTORY & PHYSICAL
DATE OF ADMISSION: 1/16/2013

47 year old gentleman who apparently has had problems with his right foot and had surgery with some hardware implanted in his foot. The patient presented to the emergency room with an open wound and visible hardware, swollen and painful foot. He was given antibiotics for it, but he did not fill them citing cost. The patient continued to have a fever and came back to the emergency room with worsening of his symptoms and he was admitted for workup and management.

HIS PAST MEDICAL HISTORY IS SIGNIFICANT FOR: 1) Hypertension 2) Peptic ulcer disease 3) Depression 4) Acute myocardial infarction 5) Bipolar disorder 6) Hypercholesterolemia.

MEDICATIONS PRIOR TO ADMISSION INCLUDED: 1) Aspirin 500 mg. once a day 2) Lisinopril 5 mg. once a day 3) Plavix 75 mg. daily 4) Ranitidine 160 mg. twice a day 5) Trazodone q.h.s. 6) Ultram 50 mg. 1-2 every 4-6 hours p.r.n. 7) Vicodin 1-2 tablets q. 6 hours p.r.n.

ALLERGIES: PATIENT STSTES THAT HE HAS ALLERGY TO IODINE.

SOCIAL HISTORY: Patient smokes and drinks, he states two packs per day.
ON PHYSICAL EXAMINATION: The patient is sitting up in bed. He is in no acute distress. Vital signs were normal.
CHEST: Clear HEART: Is normal S1, S2 ABDOMEN: Is soft, nontender. No organomegaly.
LOWER EXTREMITIES: Revealed right foot in dressing. Splint was removed. Dressing is clean and no evidence of erythema or tenderness.

LABS ON PRESENTATION INCLUDED: A CMP was essentially unremarkable. His CBC showed a white cell count of 9.6, hemoglobin 13.9 with MCV of 100.4. Platelets were 200. His ESR was elevated at 25. His PT and PTT were unremarkable.

ASSESSMENT AND PLAN: Right leg cellulitis with possible osteomyelitis. Given the patient's poor compliance, recommended to do a bone scan to decide on the patient taking IV verses oral antibiotics. The patient is very reluctant and wants to go home. I explained to the patient the dangers of doing so including infection, gangrene, and even death, and explained to him that we can decide by the end of the day on which sort of treatment we're going to be doing. The patient is not interested in that and is still insisting on signing out against medical advice.

CONSULTATION

DATE OF ADMISSION: 1/16/2013 DATE OF CONSULT: 1/16/2013

Forty-seven-year-old male.
CHIEF COMPLAINT: Cellulitis as well as hardware sticking out of his right foot.
HISTORY OF PRESENT ILLNESS: 47-year-old Caucasian male who is seen at Emergency Department. I was consulted due to hardware from a previous surgery now protruding out with an open wound of the right foot. The patient stated that he had surgery about three years ago in which he had his mid foot resected then internal fixation was then placed. He states at this time he is having some pain. In the emergency department he is receiving Vancomycin. Labs as well as radiographs have been taken.
PAST MEDICAL HISTORY IS SIGNIFICANT FOR: High Cholesterol
ALLERGIES ARE: IODINE.
SOCIAL HISTORY: He is smoking two packs of cigarettes a day. He's done this for many years. He denies alcohol use. He admits to smoking marijuana on occasion. He lives at home alone. He does have two children.
PAST SURGICAL HISTORY: Unknown injury to right foot in which internal fixation was used, three cardiac stents as well as a previous gunshot wound to the right arm in which he had to have the bullet removed.
VITAL SIGNS ARE: Blood pressure 136/88, heart rate 88, respiration 18, temperature 98.3.
REVIEW OF SYSTEMS: Are all negative other than noted above. He denies nausea, vomiting, fever, chills, or shortness of breath.
PHYSICAL EXAMINATION: Patient is alert and oriented x 3. In no acute distress.
VASCULAR: Dorsalis pedis and posterior tibial pulses are +4/4 palpable bilateral. There is minimal edema noted to bilateral lower extremities.
NEUROLOGICAL: Sharp, dull as well as protective sensation is intact to the bilateral lower extremities. Vibratory sensation is also intact.
INTEGUMENTARY: There's an open wound noted with one screwhead able to be visualized to the medial aspect of the right foot at the level of the first metatarsal cuneiform joint. There is mild erythema as well as minimal purulence noted from the site. The wound measures 0.5 cm x 0.5 cm. This probes to the hardware. There is pain to palpation upon the area as well.
MUSCULOSKELETAL: Muscle strength is 5/5 for all muscle groups of the bilateral lower extremities. There is no gross osseous deformities noted.
LABORATORY RESULTS: WBC is elevated at 12.8, his ESR is 25, his BUN is 20, and his CRP is 10.3.
RADIOGRAPHS: Reveal internal fixation noted to be mid tarsal joint of the right foot. There are screws that are broken within the level of the wound. There is one screw that is exposed to the surface.
ASSESSMENT: 1) Cellulitis right foot 2) Exposed hardware right foot.

PLAN: Full foot and lower extremity evaluation was performed at this time. Under sterile conditions with the right foot scrubbed, prepped, and draped in the usual manner, a needle driver was clamped about the screw that was exposed and this was removed. Patient tolerated the procedure well. No anesthesia was needed. Bleeding was controlled with pressure. Antibiotic ointment followed by Adaptic and a dry sterile dressing consisting of Kerlix 4 x 4s were then applied to right foot. At this time the patient will be admitted under medical for IV antibiotic therapy. He will also be ordered a walking boot. He will need in the near future removal of all hardware of his right foot as well as reconstruction of the right foot as well. This will have to be staged. He will follow up in my office on Monday and we will then discuss further surgical options and procedures at that time. The patient, again, tolerated the procedure well. He is in full understanding of his situation at this time, and I will continue to follow him while he is in house.

ADMISSION PHYSICIAN'S ORDERS

Inpatient Admission – Med/Surg
Primary Diagnosis: Cellulitis
Comorbid Diagnosis: Hypertension
Code Status: Full Code
Allergies: Iodine
NURSING ORDERS: Vital signs Q4 hours, Intake & Output Q 12 hours, Activity: BRP with assist only, Diet: Cardiac diet, NPO after midnight,
Intravenous fluids: NS @ 125 ml/hour
Medications: 1) Vancomycin (loading dose 2 grams in ED) then 1500 mg. IV Q12 hours, 2) Morphine 4 mg. IV Q4 hours prn pain, 3) Zofran 4 mg. IV Q4 hours prn nausea
1/16/13 17:35
Laboratory: CBC, CMP in AM
Ancillary consults: Occupational therapy, Physical therapy
Dispense walking boot.
1/16/13 17:58
ASA oral dose 500 mg. once daily, Lisinopril oral 5 mg. once daily, Ranitidine oral 150 mg. twice a day, Trazodone oral 150 mg. at bedtime.
1/17/13 1230 Bone Scan att. R foot 3 phase, CBC in AM
1/17/13 1500 Vanco trough 1/18/13 @ 0545
1/17/13 1730 1) may D/C home once Vancomycin completed 2) Vancomycin trough @ 0545 1/18/13 3) Then administer as outpatient Vancomycin 1500 mg. IVPB in AM (per pharmacy dose) 4) Place note on bone scan to call doctor results so that he can decide on next dose of Vancomycin due @ 1800 1/18/13 5) Aware that patient will be coming back @ 1 PM tomorrow to finish up bone scan series. 6) Depending on what bone scan shows, will determine if on IVPB or po antibiotics thereafter 7) Continue on same meds as @ home.

PROGRESS RECORD

1/16/13 Podiatry
A: 1) Cellulitis RT foot 2) Exposed Hardware
P: Pt. was seen/examined. Continue IV ABX. Pt. can WB as tolerated w surgical walking boot. He will need to have the hardware removed once his infection clears. He will then need to have his foot reconstructed in a staged fashion. The exposed screw was removed w/out complication and under a sterile field. Thank you for the consult.

1/17/13 Podiatry
Pt. seen/examined F/U for Cellulitis RLE. Pt. denies N/V/F/C or SOB. Pt. denies pain as well. Vitals stable-Afebrile.
P.E.: AOx3 NAD.
Neurovasc: status unchanged. Wound noted to medial foot RT w HPK border. No drainage noted. Cellulitis/erythema is significantly decreased. Minimal edema noted.
LABS: WBC-9.6
A: 1) Cellulitis RLE-improved
P: Pt. seen/examined. Curative IV ABX. Ok to D/C home per podiatry on po ABX. Pt. is WB w walking boot. He will follow up in my office on Monday

HEMATOLOGY	**1/17/2013**		**1/16/2013**	
DESCRIPTION	RESULTS	FLAG	RESULTS	FLAG
WBC	9.6		12.8	H
RBC	4.06	L	4.63	L
Hgb	13.9	L	16.0	
HCT	40.8	L	46.2	
MCV	100.4	H	99.8	H
MCH	34.4	H	34.5	H
MCHC	34.2		34.6	
RDW	12.0		11.8	
PLATELET COUNT	200		233	
SEGMENTED NEUTROPHIL%	71.5			
LYMPHOCYTE%	19.0	L		

HEMATOLOGY	**1/17/2013**		**1/16/2013**	
DESCRIPTION	RESULTS	FLAG	RESULTS	FLAG
MONOCYTE%	6.9			H
EOSINOPHIL%	2.3			
BASOPHIL%	0.3			
SEGMENTED NEUTROPHIL			78	H
LYMPHOCYTE			13	L
MONOCYTE			5	
EOSINOPHIL			4	
BASOPHIL			0	
PLATELET ESTIMATION			ADEQUATE	
RBC MORPHOLOGY			NORMAL	
SEDIMENTATION RATE			25	H
CHEMISTRY	**1/17/2013**	FLAG	**1/16/2013**	
SODIUM	139		138	
POTASSIUM	4.3		3.8	
CHLORIDE	104		103	
CARBON DIOXIDE	29		27	

ANION GAP			11.8	
GLUCOSE, RANDOM	102		100	
BUN	17		20	H
CREATININE	1.0		1.1	
ESTIMATED GFR	>=60		>=60	
CALCIUM	8.3	L	8.9	
AST (SGOT)	15		15	
ALT (SGPT)	15		18	
ALKALINE PHOSPHATASE	58		67	
BILIRUBIN	0.9		0.8	
TOTAL PROTEIN	5.8	L	7.4	
ALBUMIN	3.2	L	4.0	
GLOBULIN	2.6	L	3.4	H
A/G RATIO	1.2		1.2	
C-REACTIVE PROTEIN			10.3	H
COAGULATION	1/17/2013	FLAG	1/16/2013	FLAG
PT			11.0	
INR			1.1	
PTT			26.8	
URINALYSIS	1/17/2013	FLAG	1/16/2013	
URINE COLOR			YELLOW	
URINE CLARITY			CLEAR	
URINE GLUCOSE (DIPSTICK)			NEGATIVE	
URINE BILIRUBIN (DIPSTICK)			SMALL	
URINE KEYTONE (DIPSTICK)			TRACE	
SPECIFIC GRAVITY			1.030	
URINE BLOOD (DIPSTICK)			LARGE	
URINE pH (DIPSTICK)			6.0	
URINE PROTEIN (DIPSTICK)			TRACE	
URINE BILINOGEN (DIPSTICK)			0.2	
URINE NITRITE (DIPSTICK)			NEGATIVE	
URINE LEUKOCYTE (DIPSTICK)			NEGATIVE	
URINE RBC			3-5	
URINE WBC			NONE SEEN	
URINE SQUAMOUS EPITHELIAL CELLS			NONE SEEN	
URINE BACTERIA			NONE SEEN	
URINE MUCUS THREAD			NONE SEEN	
URINE CAST			NONE SEEN	
URINECRYSTALS			NONE SEEN	

PROCEDURE: XRA – FOOT AP – LATERAL – RIGHT

DATE OF EXAM: Jan. 16, 2013 04:13 PM

NUMBER OF VIEWS: Two Views

COMPARISON: Comparison is made to 1/12/2013.
DISCUSSION: Four metallic screws transfix the first metatarsal joint and also the medial and middle cuneiform. The screw traversing the base of the first metatarsal and the medial cuneiform is fractured as it was previously. A screw traverses the base of the first metatarsal which has backed out and the head of the screw immediately beneath the skin. A plated screw device transfixes the second metatarsal to the middle cuneiform. There is moderate degenerative osteoarthritis at the third, fourth and fifth tarsal metatarsal joints. There is no soft tissue gas noted.
IMPRESSION:
1) Status post intraoperative fixation of the first and second tarsal metatarsal joints.
2) A metallic screw transfixing the medial cuneiform to the base of the first metatarsal is fractured.
3) A screw traversing the base of the first metatarsal has backed out with the head in the down position immediately beneath the skin as previously seen.
4) Degenerative osteoarthritis of the third, fourth, and fifth tarsal metatarsal joints.

PROCEDURE: NUC – BONE SCAN THREE PHASE

Jan 17, 2013
DISCUSSION: The patient was administered 20 5 mCi of technetium 99m MDP and flow car post dynamic and delayed images of the feet were obtained. Exam is compared tp recent radiographs of the foot from 1/16/2013.

There is increased flow to the medial aspect of the right midfoot at the first and second tarsometatarsal junction. Post dynamic images also demonstrate increased flow to the medial right midfoot. Delayed images demonstrates moderately intense uptake in the first metatarsal cuneiform joint. Moderate uptake is also seen at the second, third and possibly fourth tarsometatarsal joints. The previous radiographs demonstrate 2 fractured screws one of which transfixes the first metatarsal to the first cuneiform and the second previously transfixed the first and second metatarsal bases. There is widening of the Lisfranc joint with reactive calcification in the region of the Lisfranc joint. Increased activity on the bone scan could be secondary to osteomyelitis or significant reactive changes related to instability at the joint.
IMPRESSION: 1. There is uptake in the midfoot most marked at the first cuneiform metatarsal joint but also increased activity is present at the second to the fourth tarsometatarsal joints. This finding could be secondary to osteomyelitis however it also could be secondary to significant instability to disruption of the Lisfranc joint with reactive changes.

CURRENT ADDENDUM:
Delayed bone phase (4 phase bone scan) of the lateral feet were obtained. There again is increased radionuclide activity present within the medial aspect of the right midfoot in the first and second tarsal metatarsal joints. In light of the increased radionuclide activity in all 4 phases, these findings are most consistent with osteomyelitis.
FINAL REPORT