**DEPARTMENT OF HEALTH AND HUMAN SERVICES** Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

December 9, 2005

Report Number A-06-04-00092

Ms. Gina Bruner
Medicare Compliance Specialist
Mutual of Omaha
P.O. Box 1602
Omaha, NE 68101

Dear Ms. Bruner:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of the Services Related To The Placement of Arterial Stents". A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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If you have any questions or comments about this report, please do not hesitate to call me at 214-767-8414 or through e-mail at gordon.sato@oig.hhs.gov, or contact Sam Patterson, Audit Manager, at 405-605-6179 or through e-mail at sam.patterson@oig.hhs.gov.

To facilitate identification, please refer to report number A-06-04-00092 in all correspondence relating to this report.

Sincerely yours,

Gordon L. Sato

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosures-as stated

**Direct Reply to HHS Action Official:**

Tom Lenz
Regional Administrator
Centers for Medicare and Medicaid Services
Region VII
Richard Bolling Federal Building
Room 235
601 East 12th Street
Kansas City, Missouri 64106

# Department of Health and Human Services

## OFFICE OF INSPECTOR GENERAL

# Review of the Services Related to the Placement of Arterial Stents


**Daniel R. Levinson**
**Inspector General**

**December 2005**
**A-06-04-00092**

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http://oig.hhs.gov

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## OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

# EXECUTIVE SUMMARY

## BACKGROUND

An arterial stent is used to hold open an artery wall after angioplasty clears the artery of blockage. The traditional stent is called a "bare metal stent." After surgery, some patients experience re-growth of blockage in the artery, which can require subsequent invasive procedures. In April 2003, the Food and Drug Administration approved a drug-coated stent designed to prevent this re-growth.

Mutual of Omaha (Mutual) and TrailBlazer Health Enterprises, LLC (TrailBlazer) are Medicare contractors responsible for processing and paying arterial stent claims billed to Medicare by Texas providers. Mutual paid about $6.5 million for Medicare Part B of A (outpatient) stent-related services provided during calendar year 2002. TriCenturion is a Program Safeguard Contractor (PSC) under contract with the Centers for Medicare and Medicaid Services (CMS) that has jurisdiction over Texas providers. CMS created PSCs to perform medical reviews, cost report audits, and other functions.

## OBJECTIVES

The objectives of our audit were to determine whether 28 paid Medicare claims for outpatient stent-placement services provided in calendar year 2002 were:

- reasonable, necessary, and allowable under Medicare rules; and
- properly coded.

## SUMMARY OF FINDINGS

TriCenturion found that 2 of the 28 claims reviewed included services that did not meet Medicare reimbursement requirements. These errors resulted in total overpayments of $4,109 and comprised:

- one claim that was partially denied because medical necessity was not sufficiently documented in the medical records, resulting in an overpayment of $2,357; and
- one claim that was partially denied due to improper coding, resulting in an overpayment of $1,752.

These errors may have occurred because the providers did not have procedures in place to ensure that the services billed met Medicare requirements. We will provide Mutual with a detailed schedule of the overpayments attributed to each provider.

## RECOMMENDATIONS

We recommend that Mutual:

- recover the $4,109 in overpayments made to the two providers included in our review; and

- through various forms of communication, provide education to these providers to ensure that the claims they submit for reimbursement for stent services meet Medicare's requirements.

## AUDITEE COMMENTS

In response to our draft report, Mutual stated that Medicare claim adjustments would be filed as the information on the denied claims is received from its archives.

Mutual stated that it agreed with the denial of four (77300, 77370, 77470 and 77783) of the five HCPCs (Healthcare Common Procedure Codes) related to the claim partially denied ($2,357) because medical necessity was not sufficiently documented in the medical records. Mutual did not agree that HCPC 92974 should be denied. However, Mutual did not provide an explanation of why the code should be allowed nor did it identify the dollar amount related to this code.

Regarding the claim that was partially denied due to improper coding ($1,752), Mutual stated that it agreed with this denial.

Mutual did not comment on our recommendation that it provide education to these providers to ensure the claims they submit for reimbursement meet Medicare's requirements.

Mutual's written response is included in its entirety in the Appendix.

## OFFICE OF INSPECTOR GENERAL RESPONSE

We do not agree that HCPC 92974 related to the claim for coronary artery radiotherapy should be allowed. TriCenturion found that the diagnosis code the provider submitted (996.74) did not support coverage of coronary artery radiotherapy. In our report, we explain that various criteria provide guidelines on the specific diagnosis codes that are considered by Medicare to support the medical necessity of these services. The diagnosis code the provider submitted is not specified in the criteria as one of the codes that supports the medical necessity of coronary artery radiotherapy. Therefore, we continue to believe all five of the HCPCs billed with the 996.74 diagnosis code should be disallowed and that Mutual should recover all of the $2,357 TriCenturion denied in its review of this claim.

# INTRODUCTION

## BACKGROUND

### The Use of Arterial Stents

Coronary artery disease is a major health problem in the United States. There has been much progress in recent years in new ways to treat this disease. Angioplasty is a technique that is used to open an area of an artery that has blockage. Following angioplasty, an arterial stent is mounted on a collapsed balloon catheter. When the balloon is inflated, the stent expands and pushes against the inner wall of the artery. The stent holds the artery open when the balloon is deflated and removed, thus allowing blood to flow freely through the artery.

The traditional arterial stent is called a "bare metal stent" and consists of a stainless-steel tube with slots. After surgery, some patients experience re-growth of blockage in the artery, which can require subsequent invasive procedures. In April of 2003, the Food and Drug Administration approved the drug-coated stent, which holds the artery open and releases medication into the body to help reduce the recurrence of arterial blockage and the need for subsequent invasive procedures.

### Medicare's Coverage of Arterial Stents

Medicare Part A (inpatient hospital services) and Part B of A (outpatient hospital services) provide for the payment of coronary stent-placement services to treat Medicare beneficiaries with arterial blockage. This report addresses Medicare Part B of A claims. Providers that bill Medicare for outpatient stent-related services are paid fixed amounts based on service groupings called Ambulatory Payment Codes (APCs).

Mutual of Omaha (Mutual) and TrailBlazer Health Enterprises (TrailBlazer) are Medicare contractors responsible for processing and paying arterial stent claims billed to Medicare by Texas providers. Mutual paid about $6.5 million for Medicare Part B of A stent-related services provided during calendar year 2002. TriCenturion is a Program Safeguard Contractor under contract with the Centers for Medicare and Medicaid Services (CMS) that has jurisdiction over Texas providers. CMS created these contractors to perform medical reviews, cost report audits, data analysis, provider education, and fraud detection and prevention.

## OBJECTIVES, SCOPE, AND METHODOLOGY

### Objectives

The objectives of our audit were to determine whether 28 paid Medicare claims for outpatient stent-placement services provided in calendar year 2002 were:

- reasonable, necessary, and allowable under Medicare rules; and
- properly coded.

## Scope

From Medicare's National Claims History File, we obtained a listing of 4,605 Texas outpatient stent claims paid during calendar year 2002. The claims included the following APCs:

- 0104 – Transcatheter placement of intracoronary stents;
- 1874 – Stent, coated/covered with delivery system;
- 1875 – Stent, coated/covered without delivery system;
- 1876 – Stent, non-coated/non-covered with delivery system;
- 1877 – Stent, non-coated/non-covered without delivery system.

We selected a nonstatistical sample of 100 provider claims from this listing. Of these 100 claims, Mutual processed 28 claims and made payments of about $148,000. This report provides the results of the medical review of the 28 claims paid by Mutual for proper disposition. We will not, however, provide separate reports to each provider included in our review.

TrailBlazer processed the remaining 72 claims. We have reported separately to TrailBlazer on those claims (Report Number A-06-04-00091).

We did not review Mutual's management controls because the objectives of this audit did not require an understanding or assessment of its management controls.

## Methodology

After selecting the 100 claims in our sample, we obtained copies of the medical records from each of the Medicare providers that submitted the claims. We provided copies of the medical records to TriCenturion, which conducted a medical review to determine if the services billed on each claim met Medicare reimbursement requirements. TriCenturion provided us with the results of its medical review. We will provide Mutual with a detailed schedule of the overpayments attributed to each provider.

We conducted our audit in accordance with generally accepted government auditing standards.

# FINDINGS AND RECOMMENDATIONS

TriCenturion determined that 2 of the 28 claims reviewed included services that did not meet Medicare reimbursement requirements. These errors resulted in total overpayments of $4,109 and included:

- one claim that was partially denied because medical necessity was not sufficiently documented in the medical records, resulting in an overpayment of $2,357; and

- one claim that was partially denied due to improper coding, resulting in an overpayment of $1,752.

These errors may have occurred because the providers did not have procedures in place to ensure that the services billed met Medicare requirements.

## CRITERIA THE PROVIDERS ARE REQUIRED TO FOLLOW

### Services Must Be Reasonable, Necessary, and Allowable Under Medicare Rules

One claim that included coronary artery radiotherapy, a procedure in which radiation is delivered during angioplasty, was billed using the principal diagnosis code 996.74 (other complications due to other vascular device implant and graft). Various criteria outline specific diagnosis codes considered by Medicare to support the medical necessity of radiotherapy combined with stent-placement procedures. These criteria do not specify diagnosis code 996.74 as a code that supports medical necessity of coronary artery radiotherapy.

Mutual's Local Coverage Determination (LCD) ID Numbers L14347 , L15087 and L15218 outline specific diagnosis codes that support the medical necessity of coronary artery radiotherapy. Diagnosis code 996.74 is not included in these codes. TrailBlazer's Medicare Part B Newsletter 02-023 also does not specify diagnosis code 996.74 as a code that supports the medical necessity of coronary artery radiotherapy.

Additionally, Title XVIII of the Social Security Act, section 1862(a)(1)(A), states that no payment may be made under Medicare Part A or Part B 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.

### Services Must Be Properly Coded

Another claim included multiple stent placements in separate vessels. Various criteria outline specific medical coding requirements for billing Medicare for multiple stent-placement procedures.

CMS Program Memorandum A-03-051 specifies the use of two codes when billing for multiple stent-placement procedures. The first code (HCPC 92980) identifies stent placement to the first vessel, and the second code (HCPC 92981) identifies stent placement to each additional vessel. Mutual's Medicare Newsletter dated July 15, 2003, reiterates this coding requirement, as does TrailBlazer's Medicare Part A Newsletter 5-96, dated October 10, 1996.

Finally, CMS National Correct Coding Policy Manual for Part B Medicare Carriers, Chapter 11 page XIA-7 states that the first reported procedure must utilize a primary code (e.g., HCPC 92980) corresponding to the most complex procedure performed. The procedures

performed in the other one or two coronary arteries (including their branches) are reported with the add-on codes (e.g., HCPC 92981).

## CONDITIONS RESULTING FROM NOT FOLLOWING THE REQUIRED CRITERIA

### Services Not Sufficiently Documented for Medical Necessity

For one claim reviewed, TriCenturion found that the provider did not sufficiently document the medical necessity of the coronary artery radiotherapy services in the medical record. The diagnosis code the provider submitted did not support coverage of these services. Thus, TriCenturion recommended denying the following five radiotherapy procedures claimed:

- 92974 - Placement of radiation delivery device;
- 77300 - Radiation dosimetry calculation;
- 77370 - Radiation physics consult;
- 77470 - Special radiation treatment;
- 77783 - High intensity brachytherapy.

### Services Not Properly Coded

For one claim reviewed, TriCenturion found that the provider used improper coding. The patient underwent two angioplasty and stent deployment procedures to two arteries. The provider billed HCPC 92980 twice when HCPC 92980 (first vessel) and HCPC 92981 (additional vessel) should have been billed.

## POSSIBLE REASONS WHY MEDICARE REQUIREMENTS WERE NOT FOLLOWED

These errors may have occurred because the providers did not have procedures in place to ensure that the services for which they billed met Medicare requirements. In addition, the providers may need additional education covering proper billing practices for stent services.

## EFFECT ON THE MEDICARE PROGRAM

The Medicare overpayments on the two claims with errors totaled $4,109 and consisted of the following:

- a $2,357 overpayment related to one claim in which the medical necessity of the services was not sufficiently documented in the medical records, and
- a $1,752 overpayment related to one claim with improper coding.

## RECOMMENDATIONS

We recommend that Mutual:

- recover the $4,109 in overpayments made to the two providers included in our review; and

- through various forms of communication, provide education to these providers to ensure that the claims they submit for reimbursement for stent services meet Medicare's requirements.

## AUDITEE COMMENTS

In response to our draft report, Mutual stated that Medicare claim adjustments would be filed as the information on the denied claims is received from its archives.

Mutual stated that it agreed with the denial of four (77300, 77370, 77470 and 77783) of the five HCPCs related to the claim partially denied ($2,357) because medical necessity was not sufficiently documented in the medical records. Mutual did not agree that HCPC 92974 should be denied. However, Mutual did not provide an explanation of why the code should be allowed nor did it identify the dollar amount related to this code.

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Mutual did not comment on our recommendation that it provide education to these providers to ensure the claims they submit for reimbursement meet Medicare's requirements.

Mutual's written response is included in its entirety in the Appendix.

## OFFICE OF INSPECTOR GENERAL RESPONSE

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# APPENDIX

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Mutual of Omaha
Mutual of Omaha Insurance Company
Medicare Division
P.O. Box 1602 • Omaha, NE 68101
402 351 5449
mutualmedicare.com
A CMS Contracted Intermediary

Report Number A-06-04-00092

September 22, 2005

Mr. Gordon L. Sato
Regional Inspector General
For Audit Services
Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

Dear Mr. Sato:

Response to the Blue Book Report A-06-04-00092 is as follows:

Provider – [redacted]
Beneficiary – [redacted]
HICN – [redacted]
Claim# - [redacted]
Dates of service – [redacted]

We are in agreement with the denial of 1 unit of 92980 under Revenue Code 0480 due to improper coding.
Page 1 of the OIG Arterial Stent Review notes under the comment section that 1 unit of 92980 can be billed for the initial stent placement; however, additional vessels must be coded under 92981.

Provider – [redacted]
Beneficiary – [redacted]
HICN – [redacted]
Claim# - [redacted]
Dates of service – [redacted]

In reference to this claim, we feel that 1 unit of 92974 should be billed with the HCPC # 92980, 92982 or 93508 under Revenue Code 0480.
We are in agreement with the denial of radiology codes 77300, 77370, 77470 and 77783 under Revenue Code 0333.

Medicare Claim adjustments will be filed as we receive the claims addressed. Because of the 2002 date, our files need to be requested from our archives. We appreciate your patience on this issue.

Thank You for requesting our view on this matter. If we can be of any further assistance on this, please let us know.

Sincerely yours,
Lynn S. Knight, RN
Lynn S. Knight, RN
RN Nurse Coordinator, Medicare Review

Office of Inspector General Note: We have redacted portions of Mutual's response containing sensitive information.